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RESIDENTIAL DRUG-FREE MANUAL

EXECUTIVE OFFICE OF THE PRESIDENT
SPECIAL ACTION OFFICE FOR DRUG ABUSE PREVENTION

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PREFACE

This is one of a series of Monographs developed by the Special Action Office for Drug Abuse Prevention to help present ideas regarding efficient and effective ways of providing drug abuse treatment services. This "how to" manual is intended for guidance only and in no way implies that this is the *only* way of providing quality care. We hope you will consider this information in light of your individual program and modify it accordingly.

This Monograph is to serve as a model for the program administrator in both the early planning stages and actual implementation phase of a Residential Drug-Free program. The concept of the residential drug-free program, its goals, treatment plans, and methods of operation, are described in this Monograph with specific implementation guidelines.

We hope you find this Monograph helpful and are able to tailor it to meet your specific drug treatment goals.

Robert L. DuPont, M.D.
Director

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EXHIBITS

I Introduction

The purpose of this manual is to describe a model therapeutic community (T.C.), its goals, treatment plans, and methods of operation. As such, it should serve as a planning document for the administrator or official who wishes to understand, establish, and operate such a drug-free treatment program. The manual, therefore, defines the concept of the T.C., presents its historical and philosophical development, describes a functioning T.C., and offers specific guidelines to be observed and followed in implementing a successful drug-free therapeutic community.

A therapeutic community may be defined as a communal, residential, drug-free rehabilitation center in which drug addiction is treated as a personality disorder. Techniques used to redirect an ex-addict's life style by restructuring or redeveloping his character vary depending upon the T.C. philosophy. All T.C.'s, however, serve to force the ex-addict to confront his problems, change or modify behavior, and learn to function effectively, drug-free. To function effectively means that the ex-addict demonstrates an accurate understanding of himself, his actions, and the behavior of others around him, an ability to initiate and conduct satisfactory interpersonal relationships, an ability to secure and maintain employment, an ability to remain uninterested and uninvolved in criminal activity, and an ability to remain totally drug-free (including abstention from alcohol abuse).

To accomplish this, the T.C. depends upon the successful integration and continued evaluation of at least three components: a highly structured system of well-supervised work and group activities; an intense schedule of varied therapeutic techniques; and an atmosphere of both support and pressure brought about by the efforts of staff and residents. These components work to guide each resident toward assuming responsibility, toward understanding his motivations, and toward living harmoniously and productively in the alternative reality of the T.C. All T.C.'s strive to accomplish this through program scheduling, in the length of time alloted for residence, and in ultimate goals.

The continuing process of critical, internal evaluation assumes a key role in the ultimate success of any T.C. Although formalized statistical measures may not need to be imposed, some form of measured evaluation must be built in—as well as a means of flexible response. Success depends upon effective treatment; to be effective, treatment must be appropriate. Flexibility can be exercised properly only if evaluation methods exist and are used regularly.

Through the mechanism of the Federal Funding Criteria (See Exhibit 1), an attempt is being made to introduce some consistency into the T.C. model. The discussion below provides a brief description of similarities and differences which have existed in terms of history, development, and philosophical approaches of several therapeutic communities.

II History

The historical development of T.C.'s can be traced both chronologically and philosophically. A brief presentation of three T.C.'s will illustrate the different treatment techniques which evolved from particular philosophical beginnings. Synanon, founded by Charles E. Dederich in 1959, was organized originally to help alcoholics. Daytop Village evolved in the fall of 1963 from a pilot program funded by a grant from the National Institutes of Health. Phoenix House began in May of 1967 when five addicts occupied the top floor of a Manhattan Upper West Side tenement to form a family unit, pool resources and energy, and engage in supportive group discussion. All three programs have developed into active and successful T.C.'s.

A. Synanon

Synanon began as a California-based foundation dedicated to the treatment of alcoholics and modelled after Alcoholics Anonymous (A.A.). The weekly free association discussion groups for AA members developed into intense group confrontations and verbal attack sessions. Their success was reflected in membership growth and the acquisition of a clubhouse. Drug addicts began appearing, and a parolee was formally committed to attend: he became drug-free within 13 months. Conflicting interests soon resulted in the withdrawal of AA members, the evolution of a residential center, and the development of the concept of self-help and self-reliance.

A few months later, Synanon became a corporation and entered the public domain. The name Synanon was pinned on the foundation when a drug addict arrived at the clubhouse and asked to enter what he meant to be a seminar or symposium. He stammered out, "I want to get into one of those 'synanons' . . . ." The name stuck. From a minimal beginning of a $33 unemployment check of Dederich's, the Synanon Foundation, Inc. has grown to a million-dollar enterprise. It is supported mainly by small donations from citizens nationwide, by lecture and media engagements, and by profitable business ventures established and operated successfully by Synanon residents. All profits are re-directed into the Foundation.

Then and to this day, Synanon has offered its members an alternative community, a *complete* refuge, a self-sufficient *permanent* home that is anti-drug, anti-alcohol, anti-tobacco, and anti-crime. It offers residents (both children and adults) those same economic, social, health, and educational opportunities available in the outside world. Employment outside is permitted, but *residence must be maintained within the community*.

B. Daytop Village

Daytop Village evolved under the auspices of the presiding judge of the Supreme Court's second judicial district in New York. A pilot project called Daytop Lodge was established to determine the value of a new therapy approach to treating addicts within a framework of relatively strict controls. Under the supervision of the New York State Probation Department, Daytop Lodge proved successful; and not long after, it became Daytop Village, Inc. Like Synanon, Daytop Village forces the ex-addict to face his problems, deal with them realistically, and grow from the experiences provided by the T.C.—that is, group activities, work responsibilities, therapeutic involvement, and peer influence. The more outstanding differences are found in Daytop's characteristic approach to treatment and in the limited length of permissible residence.

In the Daytop Village therapeutic community, the treatment cycle lasts for 16 months (previously two years). A two-phase program structure, involving specified time periods and reflected in assigned residential location, constitutes this treatment cycle. What this indicates is that the Daytop Village T.C. *expects* its residents to return to the outside world as contributing citizens. Indeed, quite unlike Synanon, Daytop Village puts time limits on residential living. It organizes its program and selects residential sites in such a way as to help members make a successful transition from the T.C. to the outside world.

The design of the program itself includes a variety of clinical therapeutic techniques and settings. Specifically, greater use is made of individual therapy, as Daytop believes that group processes have proven limited. In addition, actual residential location sites differ. Depending upon a member's progress with the T.C. treatment program, his residence may be within the T.C. at an isolated residential site geographically removed from a more familiar, tempting environmental setting, within the T.C. at a residential site located in an urban area, or entirely outside the T.C.

C. Phoenix House

Supported by City and State funds, welfare contributions from eligible residents, and other donations, Phoenix House has grown from one tenement building to 14 separate Houses serving 1,100 members. Its success is attributed largely to its mode of treatment. Like Synanon and Daytop Village, Phoenix House seeks, through T.C. techniques, activities, and atmosphere, to help ex-addicts follow a pro-social life style and develop into constructive community members. The program is similar to that of Daytop Village—and different from that of Synanon—in that treatment is characterized by a limited (18 months to 2 years) period of T.C. residence, with the goal being successful integration of members into the outside world. Phoenix House differs from Daytop Village in its choice of T.C. residential location sites and in the philosophy that underlies such choice.

Treatment offered by Phoenix House takes place where drug problems flourish; residential houses are located, by design, in areas that have high rates of drug abuse and criminal activity. This makes the treatment resources plainly visible and highly accessible to addicts. Inner city slum tenements are renovated by Phoenix House work crews. The residential houses accommodate 70-100 residents who cannot help but contrast their new constructive life style with their past, unproductive mode of living. It is thought that this awareness must occur to pave the way for personality growth and emotional commitment to the T.C. and its goals.

A number of T.C.'s modelled after Synanon, Daytop Village, and Phoenix House have risen nationwide. Most were begun and are operated by ex-addicts. Other T.C.'s have been established in mental institutions, prisons, community mental health agencies, and the like. Naturally, modifications have been incorporated by each to meet the particular needs of their members and community. Similarly, from the T.C. described in this manual, an administrator should be able to modify the model so that it is applicable to his situation—so that is is an appropriate facility offering an effective treatment plan and operated by a suitable staff.

The T.C. detailed in this manual is one which should serve as an adequate facility in an urban setting. It is one which has as its goal the return of residents to the outside community as well-integrated, constructive participants who can function effectively drug-free. The treatment program is based on this goal and, therefore, all activities and responsibilities introduced have specified time limits for completion. This is to say that each resident would be expected to progress through the treatment regimen in delineated stages until he is deemed prepared to return to the outside world. Budget allocations and staffing patterns are geared to this treatment regimen.

One important change, of which administrators should be aware, concerns the length of time spent in federally-funded T.C. programs. Previously, a 9-18 month commitment was considered reasonable; in the interests of cost-effectiveness, and in order to make this form of treatment more widely available, the acceptable time-frame in T.C. treatment has been reduced to 6-9 months, with treatment plan review occurring at 30 day intervals. Moreover, according to the Federal Funding Criteria (See Exhibit 1), T.C. residents must be employed or enrolled in either an education or job training program no later than 128 days after admission to treatment. This, of course, is in support of the selected goal of returning residents to the outside, real community as active citizens. This mandatory early participation serves two related purposes: to emphasize the goal of re-integration; and to familiarize residents, early on, with their capacity to participate positively in society.

The guidelines which follow have been determined on the basis of two major factors: cost-effectiveness and experience from the field.

A. Facility

Selecting and gaining public approval for a T.C. is often a major hurdle to program establishment. By its very nature, the T.C. requires a large, roomy facility equipped with or capable of being equipped with a kitchen. Usually, these requirements limit choices to older residential areas of the city where zoning may prove a problem. As a first step, then, the T.C. administrator should familiarize himself with appropriate zoning ordinances and health and other housing regulations applicable for joint residential and commercial use. Having done this, the administrator should weigh the pros and cons of locating the program in a high drug area. For the purposes of this manual, a facility in such an area is described. Although opposition from residents of the high drug area chosen should be expected, it is oftentimes less vociferous and of shorter duration than in more solidly middle-class areas and so may be a pragmatic choice for an administrator eager to implement his program.

A proven method for alleviating some community pressure is the establishment of a Community Advisory Board composed of representatives from the proposed neighborhood and its business sector as well as members from the local Jaycees, Kiwanis, Board of Trade, etc. Advisory Boards are helpful as support mechanisms when establishing the program and afterwards as they can provide a useful source for jobs, equipment donations, et al.

The facility, itself, should be large enough to contain a kitchen, dining area, and at least two common areas for activities and group therapy. The dining room should be large enough for staff and residents to dine together as this minimizes distance between the two. Meals should be served family style, as well, since cafeteria style may be reminiscent of institutional living. Space should be allotted for two private counseling areas, an administrative office with room for record storage and accessible only to staff, and a reception area. Although the facility should resemble a residence to foster a family atmosphere, it is important that the reception area be conveniently but prominently located close to the entrance so visitors can be screened and controlled. If possible, the areas described above should be located on the first floor. The second floor should be divided up into sleeping areas. Because men and women are treated and housed in the same facility, arrangements for separate sleeping quarters should be made. Large, dormitory-style rooms are desirable because they stimulate interaction among residents although a few small single or double rooms in each sleeping area should be reserved for residents who later achieve status positions in the program. In

planning adequate sleeping accommodations, the administrator should consider the sex ratio of the population to be served. Experience has shown that, in general, there will be a higher percentage of men than women in treatment.

Toilet facilities should be adequate in number for the population and should be designed so that privacy is afforded residents.

For T.C.'s, medical units, per se, are unnecessary and may be a hindrance to treatment since T.C. residents are taught to deal with their problems without the use of mind-altering drugs.

When selecting a facility, administrators should recall that renovation and decoration of the T.C. by the residents is an important therapeutic technique and, therefore, should choose a structurally sound building but one requiring fairly extensive work.

B. Budget

A budget for a 30 client facility is attached (See Exhibit 2) which totals about $187,000, meaning that the total cost per resident per year is $6,250. While the budget figures are approximations based on average costs from T.C.'s across the country, it is clear that the cost of T.C. treatment is high (personnel costs, alone, are over $117,000). However, administrators can institute procedures to reduce expenses. One method, successfully used in New York City, is to pool residents' welfare checks. Not only does this contribute financially but it re-enforces the residents' commitment to rehabilitation and feeling that the residence is, in fact, a home. Another way to cut costs is through the use of coupons for food purchase. Current legislation (PL 93-86) should make it possible for T.C. programs, recognized by appropriate State Agencies, to utilize the Food Stamps allotted to eligible residents. Furthermore, for the purposes of this manual, the T.C. is viewed as an independent unit which must contract out for physical exams and urine testing, a practice which raises prices. Again, administrators may opt to join with another drug treatment program to contract for these services, a step which should reduce costs. Of course, many T.C.'s are located in areas with central intake units which already provide such services. By actively participating in the central intake process as a referral source, significant savings can be effected.

C. Security

The need for security measures should be minimal as there is no medication and little money on the premises. The belongings of new admissions should be searched for contraband. Any petty cash belonging to the program or funds belonging to residents should be locked in a secure area with limited access. Entrance doors should be locked when the reception area is unattended to prevent entrance by unauthorized outsiders. Visitors should be screened to assure that they are legitimate guests.

D. Staff

Staff selection for T.C. programs is a critical area and requires careful planning. The planning aspect principally involves thorough and clear descriptions of each position, the responsibilities which accompany it, and the design of a meaningful table of organization. In addition, recruiting strategies must be developed, qualifications must be considered, training needs must be continuously assessed, and the roles of individual staff must be defined. These areas are covered in the following discussion.

1. *Staffing Patterns*

The principal considerations in designing a staffing pattern are:

a. the total number of *direct* services that can be offered in-house;
b. the number of staff responsible for each of these services; and,
c. the number of individuals directly reporting to the administrator.

Program components or units are developed in view of these considerations. In the T.C., the treatment unit constitutes the major component and most services fall under this category. However, if an exceptionally large variety of services are provided in-house, the administrator may choose to establish additional units. For example, if a program employed three vocational rehabilitation specialists, four social workers and two public assistance aides, the administrator might organize a social services unit and designate a supervisor.

Staffing requirements, then, will vary depending on the anticipated size of the program, the treatment philosophy, and the availability and quality of ancillary community resources. If the T.C. adheres closely to the original Synanon–Daytop–Phoenix models which emphasize group therapy and minimize formalized individual counseling, the number of staff could be minimal because their functions would be primarily instructive and supervisory in nature with caseload responsibility only in terms of record-keeping. If individual counseling is to be utilized as a major therapeutic tool, a ratio of one counselor to ten residents is recommended.

In a residential program, twenty-four hour coverage must be taken into consideration when determining number of staff. In some T.C.'s, one or more of the treatment staff reside in the facility, thus eliminating the need for three separate shifts. Although this arrangement leads to better treatment continuity, it may place an unrealistic expectation on staff who might find this living arrangement too demanding, emotionally. One practical way to handle twenty-four hour coverage is to rotate treatment staff on a regular basis. The minimal treatment staff required under this system would consist of a senior counselor and eight counselors, which would permit scheduling of the senior counselor and three counselors on the day shift, two counselors on the evening shift and one counselor on the night shift. The senior counselor could rotate weekends but should be restricted to the day shift because the major portion of therapeutic activities occur at that time and the senior counselor then can serve as assistant administrator in the administrator's absence. Other staff should rotate to avoid monotony. Daily meetings between shifts are essential to assure continuity. Rotation also assures that all treatment staff have input into staff meetings and case reviews.

If we assume for the purposes of this manual that there are adequate community resources for a program of 30-60 residents, the minimal staffing pattern would consist of the following:

Administrator
Secretary
Senior counselor
Eight counselors
Psychiatrist (3 hours per week)

A sample organizational chart and explanation is attached (See Exhibit 3).

Once the administrator has decided on an organizational structure and staffing pattern, he should immediately begin the recruitment process.

2. *Recruitment and Staff Qualifications*

In the discussion of the T.C.'s historical development which occurs earlier in this manual, the concept of a self-help organization of peers is reiterated several times. A large measure of the T.C.'s success can be attributed to its insistence that those individuals who have successfully overcome a problem make excellent therapists for those now grappling with the same disorder. For this reason, T.C.'s usually employ trained ex-addicts with therapeutic community backgrounds as staff. In a T.C., all staff function primarily as counselors, so the emphasis during recruitment should be on therapeutic skills. New administrators should consider contacting administrators of on-going, highly-regarded T.C.'s to request staff recommendations. Oftentimes, recent T.C. graduates will be recommended because successful completion of the T.C. program usually means that the graduate has had extensive exposure to and experience in conducting groups and understands the principles underlying the therapeutic community. Administrators should remember, however, that it is both unwise and unethical to contact participants in T.C. treatment directly. It is also unwise to hire persons who failed to complete drug treatment.

During the recruitment process, extensive interviews are very helpful because they give an indication of the candidate's ability to relate well to others. Whenever possible, group interviews should be given to each job candidate in addition to private interviews since they often expose qualities which otherwise might go unnoticed. Many programs hire as counselors ex-addicts who never have been exposed to T.C.'s. Often the first street-wise addict interviewed is accepted. Unfortunately, programs who have hired ex-addicts impulsively have had serious personnel problems as a result. For this reason, the administrator should approach the hiring of an ex-addict objectively but critically. Naturally, the ability of the candidate/ex-addict to do the job should be examined thoroughly. Questions the administrator should ask himself are: 1) Has the candidate been drug-free? 2) Is the candidate a graduate of a T.C. or does he have therapeutic experience which is appropriate to a T.C.? 3) Does he have a problem with alcohol? 4) Has the candidate any formal training in group or individual counseling? 5) If he has been institutionalized, what is his attitude about working with professionals? 6) Is he an appropriate role model? Unless the ex-addict exudes positive values and self-esteem, he will be unable to provide the leadership necessary for a T.C. Administrators should be aware of the intense pressure placed on staff in a T.C. but realize that only candidates who react positively to that pressure can be considered. While other treatment modalities can tolerate occasional manifestations of poor staff adjustment, this is not the case in a T.C. Since staff are highly visible, and rehabilitation depends so greatly on the residents' identification with staff, a consistent level of positive staff performance is essential.

Administrators might want to employ a mental health professional as both a counselor and training resource to staff and residents. Some T.C.'s have had notable success in integrating professionals and paraprofessionals, but administrators should be aware of certain problems that may arise when a professional is hired. Given his qualifications, the professional may have a superior attitude toward both co-workers and residents. This can become particularly troublesome when the professional is asked to work under the supervision of or on a peer level with a paraprofessional. Oftentimes, the mental health professional exhibits a paternalistic attitude toward residents which may interfere with discipline within the community. Nevertheless, professionals can make a strong contribution to the community if the full range of their duties and responsibilities have been explained at the outset and if the professional/paraprofessional issue is clarified.

In order to assist administrators in recruitment and hiring, position descriptions pertaining to counselors are included in Exhibit 4. These specifically detail the responsibilities involved in the job. The following is a brief overview of the counselor's role to give the administrator some idea of how the counselor should function. Hopefully, this will assist him in the recruitment and review of candidates' qualifications.

a. *Counseling Overview*

Under the direct supervision of the administrator, counselors provide residents with individual and group therapy, schedule and lead all group activities, propose new therapeutic policies, and implement those approved by the administrator.

T.C. counselors are responsible for:

1. Collecting supplemental information on designated residents using families, previous employers or co-workers, social and drug histories, and other sources as indicated.
2. Conducting orientation sessions for newly admitted residents.
3. Preparing individual treatment plans for residents and revising them when necessary.
4. Evaluating treatment plans at least every 30 days.
5. Observing resident behavior and, with input from other counselors, documenting such behavior and other pertinent data in organized, consistent progress notes (these notes are submitted to the administrator for periodic review).
6. Conducting urine testing at least once a week on a randomly scheduled basis.

The administrator, then, is responsible for evaluating and assessing the needs of the counselor. It is the administrator's decision to increase supervision, provide additional training, or terminate employees. In

addition, the administrator bears the ultimate responsibility for assuring that residents are receiving all appropriate therapeutic services, including vocational assistance.

b. *Training*

Training is an on-going need in drug treatment programs and is essential if quality care is to be provided.

Training can be conceptualized in two ways: 1) as fundamental training; and, 2) as specific skills training.

i. *Fundamental Training*

Fundamental training is the key to effective program operations. It focuses on how to train the employee to fit into an efficient therapeutic setting. Although this may appear unsophisticated, administrators should note that technical skill is meaningless without it.

Programs have found that fundamental training is best communicated through preliminary job orientation followed up by continuing on-the-job training.

On-the-job training can be accomplished in several ways, but a useful and cost-effective medium for doing so is the weekly case review or treatment team meeting. This occurs within the program and should involve the entire staff including any consultants used (e.g., the psychiatrist). Simply stated, the case review is a forum for exchanging information on specific residents' cases. Issues are explained and the status of each resident is discussed. This process permits each member of the case review team to learn from the successes and failures of others, and it offers an ideal setting to explain new concepts because the case itself affords an opportunity to understand them realistically and then apply them. Again, the case review demonstrates the proper and improper use of certain techniques and provides the kind of informal discussion necessary to assure that all staff members grasp the point being made.

At this point, a clear distinction should be drawn between case reviews and staff meetings. Staff meetings should really focus on administrative matters, that is, hours, staff rotations, pay increases, need for supplies, etc. and they should be kept separate from case reviews. Given the attention required in a well-run case review session, the administrator probably should schedule staff meetings and case reviews on separate days.

Finally, it should be stated that regardless of how effective case reviews may be for training, they cannot replace good daily supervision (See Exhibit 5 for sample training aids).

ii. *Specific Skills Training*

Once the program is established and operating smoothly, specific skills weaknesses may be detected or, because of changing resident needs, new techniques should be introduced.

One method of revitalizing and updating staff techniques and program procedures is to send one or two staff members at a time to another T.C. to reside for a few days. Usually other T.C.'s are most receptive and the cost is minimal or non-existent. Also, conferences or seminars might offer new perspectives which would be useful to the program, so the administrator might want to budget accordingly.

Other resources available for training are state- and federally-funded training conferences and centers. Here again, the administrator may find subjects of value to his staff.

Outside the drug abuse/mental health area, numerous educational resources exist which the administrator might want to consider. Courses in effective writing or management techniques are possibilities. Although few programs have the financial resources available to pay for them, the administrator might want to encourage staff to enter on their own, explaining the benefits in terms of personal growth and opportunities for promotion.

c. *Counselor Reporting Requirements*

In accordance with the CODAP client management standards, certain kinds of information should be collected by counselors on persons entering and undergoing treatment in T.C.'s. In all cases, this information should be the basis for continuing or modifying the treatment plan. For example, when the

treatment plan is initially developed during the intake process, short- and long-term goals are described, and the type and frequency of counseling and supportive services are detailed. However, as the resident continues in treatment, the validity of the original plan is tested, and the plan may then be modified based on what the information portrays in terms of progress. This information falls into four separate categories and includes:

i. Counseling and Supportive Services
ii. Medical Services
iii. Urinalysis
iv. Resident Progress

Explanations of the meaning of each of these categories follow:

i. *Counseling and Supportive Services*

The data to be recorded under this category generally include the type of services scheduled (e.g., individual or group therapy, educational counseling, vocational rehabilitation referral), the type of services *actually* provided, and the amount of services provided (one-time contact, seven sessions, etc.).

ii. *Medical Services*

These data, considered together, indicate if the medical service is provided in-house or out-of-house, give a summary of the resident's medical problems identified during the intake physical and the follow-up indicated, specify the resident's current medical problems, and describe the medication prescribed, dosages, directions, and limitations.

iii. *Urinalysis*

These data include the date the tests were scheduled, the date the tests were administered (i.e., specimen taken), and the results of the testing.

iv. *Resident Progress*

Resident response to treatment should be reviewed at least monthly. That review is to include such things as drug problems, employment, behavioral problems, and psychiatric/psychological problems.

The usual way a counselor records resident information is through the use of running progress notes. Unfortunately, though, it is also commonplace for these notes to be haphazard and uneven in quality. The thrust of more efficient standards of documentation is to force a more thorough approach to recording resident information. The key to this is understanding the relationship among the four categories of information mentioned above. The first three of these categories must be the basis upon which the assessments of resident progress are made. This means that the kinds of data specified by those first three categories must appear in the resident's record and must bear a clear and consistent relationship to the judgments of category four. For example, if a resident has shown four dirty urines during the course of a month, has not cooperated in a number of counseling sessions, and has been irresponsible about his work assignment, there should not be an entry stating that the resident is being given a weekend pass. Rather, the counselor's notes should reflect an appropriate action clearly consistent with the resident's performance.

Not only should resident progress assessments be made consistent with the recorded data, but the rationale for other activities such as referrals should be documented. The treatment plan, itself, is an example of this. If that plan includes referrals to vocational rehabilitation services or for legal help, then the reasons for including these elements in the plan ought to be clearly spelled out. If this is not done, reasons for changing such a plan are going to appear vague or arbitrary. Furthermore, such referrals must be followed up by the counselor. There is nothing wrong with a drug counselor keeping closely in touch with a vocational rehabilitation counselor to whom he has referred his client. In fact, this should be encouraged, and contacts between them should be recorded.

The following is a list of information that must be included in a counseling record (See Exhibit 6 for specific samples):

- A record must be made of the initial resident-counselor interview. The resident's name, age, race, and sex should be the first information obtained, followed by the length of primary drug abuse, attempts at prior treatment, and reason for seeking treatment at this time. Next, the counselor should record the treatment modality to which the resident has been assigned and comment on the resident's understanding of this modality. Finally, the resident's problems should be addressed, e.g., does he have housing, does he have legal problems, etc? If problems are discovered which necessitate referral to another person or agency, this should be done and recorded. In the event of a readmission, some assessment must be recorded regarding the circumstances of prior discharge(s), attitude changes, and motivation. All notes must be signed.
- A treatment plan must be developed as part of the intake process and should be thoroughly explained to the resident. The plan should include both short- and long-term resident goals, the assignment of a primary counselor, a description of the type and frequency of counseling services to be provided, a description of those additional supportive services required by the resident, and the number of urine specimens which must be given. This plan must be reviewed every 30 days.
- A note should be written after each meaningful resident/counselor contact and should include the counselor's observations, problem(s) presented, resolutions proposed, and the approximate length of time spent with the resident.
- Copies of referral forms should be included in the resident's folder. Specific reasons for referrals and information regarding the results of referrals should be obtained and documented.
- The results of counseling performed by any other person in the T.C. should be noted on the resident's chart, either by the resident's counselor or the staff member involved.
- A resident's progress should be reviewed at least monthly and summarized. The treatment plan should be reconsidered in view of the progress and either altered or continued. The summary must include the resident's legal status (both criminal and civil), employment status, current drug use including alcohol, and any other current problems and their severity. The monthly summary should reflect a composite picture of the resident's progress and not merely repeat entries made during the month.
- The date urine specimens are scheduled to be given, *are* given, and the *results* must appear in the counselor's record.
- If a client fails to keep a scheduled appointment (e.g., individual counseling, referral service appointment, etc.), it must be documented.

It is suggested that a copy of the intake form be reviewed by the counselor prior to the initial resident interview. (See Exhibit 7 for sample intake form.) This form provides much of the information required in the admission note and eliminates duplicate processing.

E. Treatment Regimen

The therapeutic community may be part of a larger drug program, but for the purposes of this manual it will be considered as an independent unit which performs its' own intake and utilizes community resources for medical and supportive services (e.g., educational, legal, jobs placement).

In discussing the treatment regimen, two methods of operation must be described; the first applies to the program in its infancy, when all participants must be considered as new admissions; the second, to the fully implemented therapeutic community, where the initial "core group" of residents has begun to incorporate program concepts. Essentially, this section of the manual traces the resident from entry into treatment until completion or termination.

1. *Intake*

Admission Interview—When an individual requests T.C. treatment, an appointment should be arranged to interview the applicant at the program. In the early stage of the T.C.'s development, the interview may be conducted by one or two counselors, accompanied by one or two residents. Once the program is fully implemented, the interview team could consist of two advanced residents and one counselor. The admission procedure is viewed as the first step in treatment. Therefore, the applicant must be prompt for his appointment and in a non-euphoric condition at the time. The purpose of the admission interview is to determine whether the therapeutic community is the most appropriate form of treatment for the applicant and to assure that the applicant understands the nature of the program, the program's expectations of him, and the fact that T.C. treatment may last from 6-9 months, depending on the resident's progress. During the interview, the admission team must get an initial personal history, medical history, and drug history from the applicant.

Recommended admission criteria for a traditional T.C. are as follows:

a. The candidate for treatment should be mature enough to accept therapeutic situations aimed at making him a *responsible adult*.

b. The applicant should not be experiencing flashbacks, psychotic manifestations, or severe physical illness requiring immediate psychiatric or medical aid.

c. The applicant must have previously abused or be currently abusing narcotics or other drugs. If an applicant is currently addicted, the T.C. offers him two choices for detoxification: either the T.C. will refer him to another program for methadone detoxification and then admit him into the residence upon completion of that procedure; or the applicant can detoxify "cold turkey" within the residence.

d. Ideally, the applicant should enter drug-free residential treatment voluntarily as this places the responsibility for rehabilitation on the applicant, himself. However, it is recommended that T.C.'s accept parolees and probationers, as well.

Once the applicant is deemed eligible for T.C. treatment, he must undergo a physical exam which in accordance with the Federal Funding Criteria (See Exhibit 1) must include the following tests:

- complete blood count and differential
- serologic test(s) for syphilis
- urine screening for drug (toxicology)
- routine and microscopic urinalysis
- SMA 12/60 or equivalent
- chest x-ray
- Australian antigen, as appropriate
- sickle cell, as appropriate
- pap smear and gonorrhea, as appropriate
- tetanus toxoid
- EKG and biological test for pregnancy, as appropriate

The intake physical should stress infectious disease, liver and cardiac abnormalities, dermatologic sequelae of addiction, and possible concurrent surgical problems. Most T.C.'s will find it more cost-effective to contract out for physical exams but should make sure that the examination results are carefully reviewed by a medical consultant.

When the physical exam is completed, the applicant is admitted to treatment immediately. (If an applicant must make arrangements regarding family, employment, housing, etc., it may be wise either to delay admission or have the T.C. make these arrangements for him.)

Once admitted into treatment, outside contact should be curtailed. Belongings should be searched, orientation arrangements made, and the intake data completed and orientation performed by a staff counselor. At a later stage of program development, orientation may be assigned to residents. At this point, the admission team reviews the intake information and the results of the physical in order to draw-up an initial treatment plan. According to the Federal Funding Criteria, the plan must include long- and short-term goals for treatment; assignment of a primary counselor; type and frequency of counseling services; and

supportive services needed. This plan must be documented and reviewed every 30 days. Likewise, it should be explained to the resident.

2. *Orientation for the newly admitted resident*

Depending on the number of new admissions accepted per week, orientation may be conducted in group or individual sessions. The counselor (or advanced resident) may show the new resident his living area, introduce him to other residents and staff, acquaint him with the facilities at time of admission. He is then assigned to a department (See Section E.3.b.—Work Program) and is expected to participate in all regular program activities.

During the first week, in addition to regular program activities, orientation sessions can be conducted daily in groups or individually, depending on the number of new residents. The purpose of orientation is to familiarize the new resident with the rules, procedures, activities, and concepts of the program. The program's expectation that each resident will share in treatment responsibilities as well as the work load must be explained. The drop out rate of residents in the first month of treatment is usually high. To reduce this, it is helpful to assign a more advanced resident as a companion and discourage the newcomer from "rapping" with other new residents who tend to influence each other negatively.

3. *Treatment*

In a T.C., treatment is a comprehensive concept which embraces therapy techniques, a work program, creative recreational activities designed to spur self-development, ancillary services (e.g., vocational, educational and legal counseling and referrals), and community-imposed discipline and rewards. Each of these items will be dealt with in individual sections, but it is vital that the administrator appreciate how these separate items are connected. In a T.C., the daily schedule is the key to the integration of the six treatment components listed above. The *schedule* is a fact of life for T.C. residents. It structures their day, and its modifications reflect their progress. Planning the daily schedule is a major activity for staff and residents and, consequently, demands regular concentrated time and attention. In planning a daily schedule, selection of activities and hours can be flexible. But it is critically important that the schedule coincide as closely as possible with a normal work day. Within that framework, residents carry out regularly assigned jobs and participate in a predetermined number of therapy groups. Recreational activities should be reserved for evenings and weekends so the work day structure within the T.C. mirrors the outside community as accurately as possible.

The following schedule is intended as a sample.

Weekdays*

	6:30- 7:30	Awaken, Dress, Straighten Room
	7:30- 8:00	Breakfast
	8:00- 8:30	Morning Meeting
	8:30-10:00	Work Assignments
	10:00-10:15	Break
	10:15-12:00	Work Assignments
		or
M-W-F	10:00-11:30	Encounter Therapy Group
M-W-F	11:30-12:00	Informal Rap Session Involving All Residents
	12:00- 1:00	Lunch and Relaxation

*A portion of time must be set aside during each week for a randomly scheduled urine test.

	1:00- 2:30	Seminar
	2:30- 5:00	Work Assignments
	5:00- 5:30	Free Time—Clean up for Dinner
	5:30- 6:00	Dinner
	6:00- 8:00	Free Time, Orientation for New Residents
	8:00- 9:00	Evening Seminar
		or
M-W-F	8:00- 9:30	Encounter Therapy Group
M-W-F	9:30-10:00	Informal Rap Session Involving All Residents
	10:00-10:45	Free Time
	10:45-11:00	Quick House Cleaning Before Bedtime

Rules and Recommendations, Re: Daily Schedule

1. Residents must straighten rooms prior to breakfast. No resident may miss breakfast on weekdays. Promptness to meals as well as meetings or any activity must be enforced.
2. Following encounter group therapy sessions, whether held during the day or in the evenings, a brief period should be allowed for all residents to gather informally. Tensions, frustrations, and anger will be high in some instances, and the informal group offers a "cooling down" period.
3. Whenever there is free time during the work day, residents should be encouraged to talk with one another.
4. No sleeping is permitted during the day.
5. Evening and weekend seminars should be lighthearted.

Weekends

9:30-10:00	Awaken, Dress, Straighten Room
10:00-10:30	Breakfast
10:30-11:30	General Housecleaning
11:30- 1:00	Free time for personal matters: laundry, letter writing, etc.
1:00- 2:00	Dinner
2:00- 6:00	Free time (planned recreation, field trips, or receiving visitors for some residents)
6:00- 6:30	Supper
6:30- 8:00	Free time for T.V., relaxing, taking care of personal matters
8:00- 9:30	Seminar
9:30-12:00	Free Time

Those residents who have earned passes may utilize them during weekends (passes are explained fully in Section 3.f Rewards). The weekend schedule can be flexible to accommodate T.V. viewing, sports interests, and outside activities.

a. *Therapy Techniques*

In general, five different types of therapy are conducted in a T.C.: morning meeting, supportive group or probe, relatives groups, encounter groups, and individual counseling. It is imperative that therapy be conducted by trained staff or, once the program is functioning for several months, by residents whose progress and understanding of group skills justifies assumption of this role.

In accordance with the Federal Funding Criteria (See Exhibit 1), T.C.'s must conduct randomly scheduled urine tests once a week as part of their treatment regimen and have the results analyzed for morphine, methadone, cocaine, codeine, amphetamines, barbiturates, and other drugs, if indicated. (T.C.'s

probably will contract out to a private lab for urinalysis, but administrators should note that the lab used must comply with Federal and State proficiency testing programs. Additionally, urine results should be recorded in the resident's on-going progress notes and the notes should explain how the results are used in therapy.)

i. *Morning Meeting*

The purpose of the morning meeting is for staff and residents to become aware of the day's activities and appointments, to handle minor community problems, and to begin the work day in good spirits. It is comparable in daily life to reading the newspaper, having that last cup of coffee, and kissing the spouse good-bye. The "hidden agenda" of the morning meeting is to eliminate residents' excuses for missing appointments. In addition, valuable therapy time is not wasted on minor complaints if they are settled in the morning meetings. The entertainment portion forces people to develop self-confidence and come out of their shells. Furthermore, residents (and staff) are required to put aside individual facades. This exercise provides a vehicle to enhance interpersonal relationships.

The staff member (or an older resident) in charge of the group appoints someone to read the program philosophy. The group leader reads the daily log of visitors expected and scheduled appointments for residents. Someone may summarize an important news item from the newspaper.

The leader requests gripes. Residents mention minor complaints (e.g., the shower was left dripping, the sink was dirty, my socks are missing, etc.). Guilty parties are expected to confess. Admission of guilt in response to various complaints usually does not warrant any disciplinary action, but the guilty parties are expected to rectify the situation.

Before closing the morning group (usually the final 10 minutes), volunteers are requested to tell jokes, sing a song, do a dance, or read a poem. Four or five people perform at each meeting. If a resident (or staff member) does not volunteer for two or three days, the group leader selects him to perform. Then, the group is adjourned.

ii. *Supportive Group or Probe*

The purpose of the supportive group or probe is to provide a structured opportunity for clients to alleviate excessive guilt. The group meets twice a week, preferably in the evening, in a relaxed setting (dimmed lights, comfortable chairs). The discussion focuses on experiences from the past about which residents still feel guilt. Any group member may begin the session. Others in the group verbally identify with his experiences or give advice as to how to handle the guilt feelings. Acceptance of the person, regardless of his past behavior, is emphasized. Such material as homosexual activities (especially for people who have been incarcerated), mistreatment of relatives and friends, physical violence, feelings about self-image, etc., are discussed. No laughter or ridicule is allowed. Nothing said in the group can be repeated outside the group. No observers are ever allowed. All participants (especially staff) must be willing to expose their own feelings because onlookers and observers, even in a staff role, are destructive to the process. It is often useful to have one group per week for all residents and to divide the second so that males and females are separated and may express their concerns more freely. In the supportive group or probe, individuals are encouraged to develop a sense of conscience; therefore, the goal is not to eliminate all guilty feelings, but to gain insight into feelings so that excessive and crippling guilt may be reduced.

The supportive group is a potent therapeutic tool and should not be attempted without a trained leader who is thoroughly versed in its conduct and experienced in nonjudgmental counseling. The group leader's experience is stressed because implementing a supportive group can be difficult. The leader must recognize when the group is off-target and re-focus it, must be able to elicit participation from passive members, and must understand when the group exhausts a subject and subtly redirect it to another topic about which the group may have some concern.

iii. *Relatives Group*

The purpose of this group is to orient families to the program, its concepts, rules and regulations, and to help families learn about more constructive ways of dealing with the resident.

The relatives group is a weekly evening session conducted by a staff member for residents' relatives and close friends but it excludes the residents themselves. The group affords the family/friends opportunities to ventilate hostility or anxiety about the resident and/or the program without interfering with the residents' treatment. Problems concerning residents' demands on the family and methods for dealing with these are material for this group. This is a vital effort since the resident will soon return to his family and friends who may be instrumental in his rehabilitation.

iv. *Encounter or Confrontation Therapy Group*

The encounter or confrontation therapy group is an essential tool in the T.C. and should be scheduled three times weekly. The group encourages catharsis by allowing residents to verbalize hostile feelings through shouting and profanity or other acting-out mechanisms. The group serves as a vehicle for behavioral change during which residents describe how each other's negative behavior is perceived and demand that changes be made regarding those aspects that are unacceptable to them.

The encounter therapy process has three elements: 1) direct confrontation about behavior or attitudes; 2) provision of information regarding changes that can be made; and 3) "patch-up" to assure that the individual understands that the particular behavior, not the person, is unacceptable.

Encounter groups should be led only by counselors with strong directive abilities since they serve as the catalyst for group interaction. The group leader must steer the group toward real issues and understand various techniques for this kind of control. (For example, if one group member attempts to take control, the leader must be skilled enough to confront him about his behavior, or arouse the group to question the member's tactics, or distract the group with another issue.) In addition, the leader must be able to recognize and halt encounters that are unproductive or detrimental. For effective encounter groups, it is helpful to maintain as consistent a composition as possible. The group gains strength as members come to know each other and no longer rely on forced issues. For this reason, the introduction of strangers (new residents) into an on-going group is not recommended. In general, encounter groups establish two rules: 1) violent actions are prohibited; and 2) no outside discussions about the group are permitted.

Staff should be cautioned about admitting residents whose patterns for dealing with problems are personally destructive. Experience has demonstrated that residents with histories of substantial amphetamine abuse often fall into this category.

v. *Individual Counseling Therapy*

If individual counseling is deemed necessary, it may occur at any time, day or night. As some T.C.'s emphasize group therapy, formalized individual counseling sessions are unnecessary. In addition, individual counseling may weaken the impact of group therapy, and therefore many T.C.'s discourage it. Whether individual counseling is a formalized structured aspect of treatment or handled "as needed," the program's treatment policies should be adhered to and progress notes must be made.

b. *Work Program*

A T.C.'s work program consists of assigning residents to jobs in the various departments (Housekeeping, Seminar, Acquisition, Kitchen, Business Administration, Public Relations, Expediting, et al.), which are developed to occupy the residents constructively and assist in the smooth, daily operation of the community. Departments may be changed as the T.C.'s needs dictate. For example, a new T.C. might want to establish a Renovation Department and later replace it with a new, more appropriate department.

Although the jobs keep residents busy, teach certain job skills, and prove financially rewarding to the program, these issues are secondary to the main purposes of the assignments: namely, to teach individuals how to relate to others, give and take directions, and assume responsibility for their resocialization. The conflicts that arise, when discussed in groups, provide a means for residents to gain self-awareness.

The procedure for assigning jobs should be constantly reassessed, remembering that while residents may be adults, they are adults who are unable to handle their lives responsibly and need to *learn how*. It is as damaging to a resident to receive responsibility for which he is not yet ready as it is to receive a privilege

he cannot yet handle. A system for the individual to handle gradually increased responsibility and authority is more beneficial. *Initially*, it is a staff responsibility to make job assignments in one of the established departments, based on residents' needs and potentials, and to supervise the performance of those duties. As treatment progresses, responsible residents are appointed department heads and assume supervisory roles. Whenever possible, a staff member oversees the department and advises the department head to assure continuity of procedure.

Workers are assigned to various tasks and have their performance closely supervised by the department head. When a job is done incorrectly or incompletely, the department head demands that it be done correctly. Workers are not assigned tasks in isolation, but in small groups whenever possible. There will be numerous conflicts due to the job assignments and residents working together. These produce valuable material for group confrontation sessions.

i. *Housekeeping or Service Department*

The purpose of this department is *NOT* to train people to be janitors but to teach people to work together responsibly and to follow directions. This is the logical department to which new residents are assigned. A resident is promoted from this position based *not* on his housekeeping skills but on his ability to follow directions without hostility and on indications that he is able to handle increased responsibility.

The department head assigns a few workers to sweep floors daily, wash and polish floors as needed, wash windows and walls, and take responsibility for arranging furniture and equipment for any special activities. The Housekeeping or Service Department is responsible for keeping coffee cups and ashtrays clean and for cleaning bathrooms and offices, as well as all other areas of the facility. The members of this department thereby assume the responsibility for the discipline of other residents concerning cleanliness of the facility.

ii. *Seminar or Creative Energy Department*

The purpose of the Seminar Department (Creative Energy Department) is multifold. It serves to expand the residents' horizons; it is educational; and it develops poise and self-confidence in public speaking and in daily life. As many staff as possible should participate with residents in this department. This accelerates the getting-acquainted process and serves to break down staff-resident barriers. Initially, a staff member will be important in assisting the department head with developing seminar schedules. Later, this function can be totally assumed by the residents.

The department head is responsible for arranging and occasionally presenting one or two seminars daily. Other residents assist the department head in planning and presenting seminars. Those residents who are reluctant to speak in groups or have difficulty verbalizing should be assigned to this department. Presentations can include consumer education, health care, poetry, literature, etc. and may be given by guest lecturers, staff, or residents. Other topics that can be presented by residents in the department include various program rules, news items from the daily paper, discussions of the Synanon or Daytop books, debates on any topic, mock speaking engagements, charades, grab bag speeches, and role playing of job interviews and making dates.

iii. *Acquisition Department or Hustling Crew*

The purpose of this department is to develop the "self-help" concept and a sense of family unity within the program. The resident gains self-esteem when the outside community responds with approval.

In executing the responsibilities of this department, all department heads notify the head of Acquisition Department about program needs such as food, clothing, furniture, and books. The Acquisition Department makes contacts in the community with supermarkets, department stores, and other local outlets for contributions and makes arrangements to pick up donated items. The Department is also responsible for writing prompt thank-you notes for all donations.

iv. *Kitchen Department*

The purpose of this department is not to train chefs and kitchen helpers but to teach people to work together responsibly and to develop self-confidence. The kitchen is unique in that all residents evaluate the results of that department three times a day and are usually vocal about any errors that are made. Workers learn to function responsibly in the face of criticism.

The department head is responsible for preparing all meals and for maintenance of the kitchen. The department head must plan menus, assign workers to the various tasks involved in preparing and serving the meals, and supervise clean-up and care of equipment. The department head is responsible for teaching his workers to cook and may be responsible for ordering supplies and keeping inventory.

v. *Business Administration Department*

A resident is appointed to this department after having demonstrated a high degree of responsibility in performing the job assignments described above. It is a suitable assignment for those residents who lack confidence in their ability to organize and express themselves on paper. This department prepares and types program correspondence and internal memos. In addition, the department types material needed by other departments such as requisitions for supplies, schedules, etc. The department head is responsible for assuring a smooth work flow and supervising the quality and quantity of work.

Among other lessons learned from this department is how to function within a business-like setting, since much of the work is interdepartmental and requires coordination, and how to organize time in order to accomplish a list of assignments varying in length and difficulty.

vi. *Public Relations Department*

This department is suitable for those residents who have already acquired a certain degree of organizational and business skill but are in need of more self-confidence and poise. The public relations department can prepare a regular weekly or monthly newsletter about program activities, handle speaking engagements, publicity, drug education for schools and community agencies, hours of the program for interested citizens, etc. Also, this department can compile basic statistics about program participants for brochures, budget justifications, etc. Public Relations serves as liaison between the program and other community agencies and the criminal justice department (for those T.C.'s accepting parolees and probationers).

The department head must develop and coordinate these functions, and must closely supervise the workers as, in many instances, this will be the *first opportunity for on-going contact outside the T.C.* Public Relations provides an excellent opportunity for residents preparing to re-enter the community to test their ability to handle the pressure accompanying that move.

vii. *Expediting Department*

The Expediting Department is responsible for coordinating all departmental activities, for providing initial orientation regarding job assignments to all newcomers, for rotating residents through departments, and for reporting the status of all departments and individuals to the administrator. Expeditors facilitate the smooth operation of all departments, are responsible for knowing the status of all individuals and departmental units, and are also responsible for reporting all significant occurrences to the appropriate staff. This department places considerable stress upon its workers and therefore is reserved for fairly advanced residents.

c. *Creative Recreational Activities*

In a T.C., recreational activities are confined to evenings and weekends and strive to duplicate the leisure pastimes of the outside community. For this reason, arts and crafts activities (often associated in residents' minds with institutional care) are downplayed. Rather, the T.C. encourages small groups (five

residents or less) to attend a movie or play, tour a museum, etc. Occasional activities for the entire community such as a picnic or sport are organized, but these are considered special events. Administrators may be approached by volunteers who offer to arrange painting classes or other craft activities in a similar vein. If the offer is accepted, it is important that the classes occur in the evenings or on weekends so that the work day schedule is not interrupted.

d. *Ancillary Services*

As the T.C. is geared toward total rehabilitation of its residents and their successful reintegration into society, it is crucial to provide ancillary services, either in-program or by referral. (The Federal Funding Criteria require that legal, educational, and vocational services be provided, and if achieved through referrals to outside agencies, these agreements must be documented. In addition, the T.C. must have a formal, written agreement with a community hospital for provision of emergency, in-patient and ambulatory medical services.) Program staff, staff of other agencies, or volunteers may be utilized to provide seminars or courses on specific subjects or to work with selected individuals. While residents are in the early phase of treatment, such topics as money management, sex education, family planning, etc., are appropriate. As the resident progresses, educational and vocational exploration should begin. Clinical indications for this would be measured on an individual basis, granting human and program flexibility. Once the resident is nearing this re-entry phase, by giving evidence of vocational or educational readiness, referrals can be made to the in-house specialist (e.g., jobs development counselor) or outside educational and vocational rehabilitation institutions. In all cases, frequency and type of service provided must be recorded by the residents' primary counselor and followed up. In addition, results and/or problems incurred must, likewise, be documented by the counselor.

e. *Disciplinary Measures*

T.C.'s utilize a variety of learning experiences to expedite behavioral change (e.g., Synanon is renowned for shaving heads of residents who failed to abide by program regulations). Many T.C.'s have modified the severity of the learning experience but continue to follow the principle that immediate action is required following any deviation from acceptable behavior. In imposing discipline, it is important that a variety of different learning experiences be utilized so that each has an element of surprise and, therefore, carries an impact. These could include giving a stern lecture, demotion to a less responsible job, assigning the wrong-doer a seminar topic to present at the next morning meeting, or issuing signs or symbolic objects to be worn. These techniques often incorporate the use of ridicule to change the inappropriate behavior.

It may be necessary to use termination from treatment as a disciplinary measure. If the terminated resident seeks readmission, he must reapply for admission in the usual manner. Usually, criteria for readmission are based on the program's knowledge of the individual and are, therefore, more stringent than the normal admission criteria.

f. *Rewards*

Rewards in terms of outside visiting privileges or passes are incentives for responsible behavior and serve as useful steps towards gradual re-entry to the community. As a general rule, T.C.'s permit no outside contact during the first six weeks of treatment. After the sixth week, a resident may make a formal request, through his primary counselor, to the treatment team for permission to write a letter to his family. If the family replies, the resident may then request permission to telephone the family. Over the next few weeks, requests may be made and permission given for letters, then calls, to girl friends and boy friends. If the resident continues to respond positively to treatment, he may be allowed to shop in the neighborhood accompanied by another resident, then by himself. Next, the resident may request a visitor. At first, all visits must take place in the presence of another resident. The purpose of this regulation is to place some restraints on the initial visits so that the resident does not become unduly upset. Once he feels comfortable with visiting, he may do so in the residence, unaccompanied. After three months in the T.C., a resident may request permission to visit his home for a few hours accompanied by another resident. Again, if he is able

to handle the home environment, he can visit by himself. After four months of successful response to treatment demands, the resident may request overnight passes for home visits which may be extended to weekend overnight privileges. In essence, rewards are milestones for residents which concretely mark their progress and motivate them to return to the community.

4. *Re-entry*

When the resident has participated effectively in the T.C. for 120 days, plans must be made for him to re-enter society. Re-entry is a major and critical phase of treatment. It is important that the resident make a gradual transition from the "in-treatment" status to that of being an independent citizen. The re-entry phase serves as a testing ground to determine whether the resident has incorporated the concepts and values of the program sufficiently to become a productive, responsible citizen. Re-entry provides the "real-life" situations while offering program support to help the individual adjust to an environment with which he actually has little positive experience.

Typically, a resident will feel that he is ready for re-entry before the staff reaches that same conclusion. In order to gain approval for re-entry, the resident must prepare a plan outlining specific goals that he will pursue during the re-entry phase (e.g., employment in a specific field, job training leading to a specific position, enrollment in an educational program). The plan is discussed by the resident with his primary counselor and then presented by the counselor to the treatment team. In evaluating a resident's progress and determining his readiness for re-entry, the treatment team should consider whether the resident has consistently displayed responsible behavior and whether he has received maximum benefit from in-residence activities. The team must also evaluate whether the resident's plans are realistic and feasible for him.

Once the resident's plans meet with the team's approval, the resident begins the first step of re-entry. He is excused from most program activities to pursue his outside endeavors. These may consist of full- or part-time employment and/or full- or part-time school or training depending upon his needs and abilities. He relinquishes his job responsibilities and title within the T.C. but continues to reside there, abide by all program regulations, and participate in selected program activities. Program involvement during re-entry may include participating as a leader in some encounter groups and occasional seminars, being available as a role model to other residents, and participating in counseling sessions geared to re-entry.

When he has demonstrated the ability to handle his new responsibilities and freedom, with satisfactory performance at work and school, appropriate handling of alcohol, and adequate participation in the program, he moves into the second stage of re-entry: residing outside the program. His commitment should then consist of regularly scheduled returns to the T.C. to continue in re-entry counseling groups.

If the individual experiences serious difficulties at any point in the re-entry process, he should be able to return to in-residence status and to resume intensive treatment without the stigma of "failure."

When the resident has shown a satisfactory adjustment to re-entry over a period of a few months, he may be considered as a candidate for graduation.

5. *Graduation*

Graduation signifies the completion of treatment and the commencement of a new phase in the participant's life. It should be a formal activity and may involve one or more participants. A ceremony, diplomas or certificates, etc., are appropriate.

Graduation Criteria

1. Gainful employment or status as a student in good standing.
2. Established residence outside the T.C.
3. Savings account in a bank.
4. Re-entry counseling completed.
5. Indications of having stabilized well (e.g., good family relationships, pride in employment).

A graduate may continue to visit the T.C. and participate in occasional activities. It is expected that participation will taper off as the graduate establishes relationships external to the T.C. While he continues to return, he should be treated with respect by residents but will have no designated position within the program.

6. *Follow-up*

A formal written follow-up evaluation should be conducted after one year through a personal interview with the graduate. If possible, a yearly written questionnaire or personal interview should be conducted thereafter. The follow-up interview can also serve as a mechanism for an internal evaluation of the program. As mentioned earlier, critical self-evaluation and receptive response mechanisms are crucial to a philosophically and functionally sound T.C.

7. *Termination*

As a therapeutic community must provide consistent discipline, program rules should be firmly upheld. Three violations which should warrant immediate termination are:

1. Any drug or chemical abuse.
2. Any physical violence or threat of physical violence.
3. Any sexual activity within the program.

Termination may result from other violations, depending on the circumstances. It is not appropriate to transfer a resident to another drug treatment facility as a disciplinary action.

8. *Drop-Out*

A resident should be considered as a drop-out when he leaves the community against program advice. The T.C. should retain the individual on its rolls no longer than 24 hours after departure. At the time of departure, the individual either should take his belongings or donate them to the program. A re-entry member living in the community but failing to comply with his commitment should be considered a drop-out after two weeks. A drop-out should not be allowed to visit or participate in program activities on an informal basis but may reapply for admission in the usual manner.

9. *Transfer*

Transfers are appropriate when another mode of treatment appears more suitable for the individual than the treatment offered by the T.C. When the treatment team believes that the resident requires a different treatment mode, this insight should be communicated to the resident and a transfer arranged. Intake data, treatment plan, and progress notes should be sent to the new program and, if feasible, a T.C. staff member should accompany the resident to the new program for the initial visit.

IV Summary

In conclusion, the administrator should remember that this manual offers guidelines and not laws, although it is consistent with the Federal Funding Criteria.

Throughout this document, there has been an attempt to support the administrator's decision-making role. The Federal government, likewise, acknowledges the importance of this stance. For this reason, a formal procedure is available to administrators to express disagreement or request exceptions to the current criteria. When administrators believe that it is in the best interests of the resident to seek such a change, they should send a written request to:

Director
Division of Community Assistance
National Institute on Drug Abuse
11400 Rockville Pike
Rockville, Maryland 20852

Exhibit 1

FEDERAL FUNDING CRITERIA

FEDERAL FUNDING CRITERIA FOR TREATMENT SERVICES*

The contractor/grantee, as an independent contractor/grantee and not as an agent of the Government, shall provide the necessary facilities, material, services, and qualified personnel to furnish treatment and rehabilitation to drug dependent persons in accordance with the following:

1. The contractor/grantee shall provide and operate or shall engage subcontractor/affiliate to provide and operate such _____ (modality), as may be appropriate, at a site or sites to be approved by the Government.

2. Criteria to be used for patient admissions and terminations shall be established.

3. All facilities shall be maintained in a clean, safe, and attractive condition and in accordance with appropriate local, state and Federal codes and other laws.

4. Appropriate furnishings for a _____ (modality) shall be provided.

5. At intake, an initial personal history, medical history, and drug history must be taken. It is important to conduct this intake process as rapidly as possible so that clients are not discouraged from pursuing treatment. An intake not exceeding three days is optimal. The purpose of taking a medical and drug history is to immediately identify the client experiencing flashbacks, psychotic manifestations and/or severe physical illness requiring immediate psychiatric or medical care. Only when this information is collected and reviewed can the program be reasonably assured of preparing the best possible treatment plan for the client. It is in this context that a complete personal, medical, and drug history is essential for all treatment modalities.

*For the following treatment modalities: Outpatient Methadone, Residential Methadone, Residential Drug Free, Outpatient Drug Free, and Day Care Drug Free.

Programs having difficulty complying with any of the Federal Funding Criteria should request technical assistance from their Program Development Specialist, Division of Community Assistance, National Institute on Drug Abuse, 11400 Rockville Pike, Rockville, Maryland 20852.

6. At intake a physical examination and laboratory examination shall be performed by qualified personnel. Programs shall perform physical examinations on clients as soon as possible after entering treatment but no later than 21 days. The physical examination shall be detailed in the treatment plan. It is particularly important that residential drug free programs perform physical examinations as soon as possible because of the possibility of infectious diseases and the close client contact. If the residential program has an induction phase, it is recommended that the physical examination be performed during this time period. This criterion is not meant to supercede FDA regulations requiring a physical examination at intake. The minimum for a physical and laboratory examination may consist of the following:

   a. Physical examination stressing infectious disease, pulmonary, liver, cardiac abnormalities, dermatologic sequelae of addiction and possible concurrent surgical problems.

   b. Complete blood count and differential.

   c. Serologic test(s) for syphilis.

   d. Routine and microscopic urinalysis.

   e. Urine screening for drugs (toxicology).

   f. SMA 12/60 or equivalent.

   g. Chest X-ray.

   h. Sickle cell, as appropriate.

   i. Australian antigen, as appropriate.

   j. EKG and biological test for pregnancy, as appropriate.

7. Each new admission or readmission shall be interviewed by a mental health professional. Mental health professional is defined as "a person who, by virtue of training and experience, is capable of assessing the psychological and sociological background of a client to determine the optimal treatment plan." The staff shall take a complete personal history: family; education; vocation; legal and related areas; drug history, including kinds of drugs abused and when begun, prior treatment attempts; and any other relevant information. The admission interview is regarded as the first step in treatment for all treatment modalities. The purpose of the admission

interview is to determine whether the selected mode of treatment is most appropriate for the client and to ensure that the client understands the nature of the program and the program's expectations of him. Again, our primary concern is that enough information is exchanged between the client and the program to ensure that the best possible treatment plan is designed for the client in light of his treatment needs and the program's expectations. (Note: Where a Central Intake Unit (CIU) provides the intake screening, it is the responsibility of the program to which the referral is made, to develop the individual treatment plan for each patient after careful review of the records and an interview with the client.)

Individual treatment plans shall be reviewed and redetermined by the treatment team no less than every 90 days for outpatient programs. For all other modalities, the individual treatment plan shall be reviewed and redetermined every 30 days. Evidence of this review shall be recorded in each patient's medical record. Every treatment plan must include documented evidence of:

a. A statement of short and long-term goals for treatment generated by both staff and client.

b. The assignment of a primary counselor.

c. A delineation of the type and frequency of counseling services to be provided.

d. A delineation of those supportive services needed by the individual patient.

8. The program shall designate a medical director who must take medical responsibility for the program and be licensed in the jurisdiction within which the program exists. He shall ensure that the initial evaluation is appropriately performed and that the medical needs of individual patients are periodically assayed and that, when appropriate, emergency medical services are provided. It is the responsibility of the medical director to determine what emergency medical equipment and supplies are needed in order to deal with possible overdoses and other medical emergencies. Medical services, in general, should be provided through city or county medical facilities. Provision of such services is not the program's responsibility.

For those patients receiving prescription medication (other than methadone), through the program, contact with a program physician is required at least once every four (4) weeks or more frequently, depending on patient needs.

9. A formal written agreement must exist between the program and a licensed hospital or hospitals in the community for provision of emergency, inpatient, and ambulatory medical services as appropriate. Such services will not be paid for under this contract/grant.

10. At least five hours per week of professional mental health consultation per 100 patients must be provided. The purpose of this consultation is to review selected cases and to provide assistance to staff in patient management or referral for psychiatric services.

11. A variety of counseling techniques may be utilized in individual, family or group counseling sessions conducted by trained personnel under the supervision of an appropriately qualified professional. In any group counseling, the size of the group shall, in general, range between 5 and 15 individuals. In outpatient methadone and outpatient drug free programs, each patient shall have available to him a minimum of 3 hours per week of counseling. In residential drug free, residential methadone, and day care drug free programs, a minimum of ten hours per week of formalized counseling shall be available for each patient. These counseling guidelines should be considered minimum for planning purposes; however, the actual counseling time allotted should be based upon individual client needs.

12. The following supportive services must be provided:

    a. Education.

    b. Vocational counseling and training.

    c. Job development and placement.

    d. Legal services.

    To the maximum extent possible, programs shall utilize community resources. Documentation of any agreements to provide the above services must be obtained. If any program can adequately demonstrate inability to obtain the requisite supportive services, it may submit a formal request for the direct provision of these services.

13. The following procedures must be observed for urine surveillance except for outpatient drug free:

    a. Urine specimens from each patient must be collected under appropriate supervision on a randomly scheduled

basis at least once a week and analyzed for morphine, methadone, cocaine, codeine, amphetamines, barbiturates, as well as other drugs if indicated. Breath analysis is acceptable for alcohol testing where appropriate.

b. Laboratories used for urine testing must comply with all state and Federal proficiency testing programs.

c. Urine testing results shall be used as a diagnostic tool and in patient management and in the determination of patient treatment plans. Patient records shall reflect the manner in which test results are utilized.

d. Provision for urine testing of outpatient drug free clients should be made, and used by program staff as appropriate.

14. Every patient shall be encouraged to enroll in either an education program, a job training program or gainful employment as soon as appropriate, but not later than 120 days; or in the case of a referral from a residential program, not later than 60 days after the date of transfer. Any exception to this requirement shall, in every instance, be recorded and justified in the patient's record. Clients have the right not to become involved in these programs; however, they should be encouraged to do so as a basic element of the treatment plan.

15. Each program shall establish a follow-up policy which encourages a schedule of minimum contact available for discharged patients.

16. Each program shall establish a patient record system to document and monitor patient care. This system must comply with all state and Federal reporting and confidentiality requirements.

17. An effort must be made to gear the program's hours of operation to meet client needs. For outpatient treatment programs, consideration should be given to those clients who are employed and consequently must be able to visit the clinic outside of working hours. Clients who are not employed or involved in school or training programs are expected to schedule other activities around clinic hours. The traditional 9:00 a.m. to 5:00 p.m. work day regimen is not adequate for outpatient treatment. In fact, in clinics with large client populations, twelve-

hour clinic operations may prove necessary. However, the minimum hours of operation shall be maintained.

a. Outpatient Methadone -- no less than 7 days per week: 5 days per week at 8 hours per day (in all cases at least 2 hours must be outside 9 a.m. - 5 p.m.) and 2 days per week at 4 hours per day.

b. Residential Methadone and Residential Drug Free -- 7 days per week, 24 hours per day.

c. Outpatient Drug Free -- no less than 6 days per week: 5 days at 8 hours per day (in all cases at least 2 hours must be outside 9 a.m. - 5 p.m.) and one day at 5 hours.

d. Day Care Drug Free -- 6 days at 10 hours per day.

e. Central Intake Unit -- 5 days per week at 8 hours per day.

18. Residential methadone and residential drug free programs must provide a minimum of 3 meals per day per patient. Day care drug free programs may provide one meal per patient per day.

19. All programs which use methadone for detoxification and maintenance treatment must comply with the regulations of the Food and Drug Administration and also must function in compliance with all other relevant Federal and state regulations and guidelines.

Exceptions to the underlined criteria, when in line with patient needs, may be granted by your Program Development Specialist, Division of Community Assistance, National Institute on Drug Abuse, 11400 Rockville Pike, Rockville, Maryland 20852. Exceptions to other criteria will be made by: Director, Division of Community Assistance, under the advisement of the Clinical Review Board.

FEDERAL FUNDING CRITERIA FOR TREATMENT SERVICES
CENTRAL INTAKE UNIT

The contractor/grantee, as an independent contractor/grantee and not as an agent of the Government, shall provide the necessary facilities, materials, services, and qualified personnel to provide central intake services to service delivery systems which furnish treatment and rehabilitation to drug dependent persons in accordance with the following:

A. The contractor/grantee shall provide and operate or shall engage a subcontractor/affiliate to provide and operate a Central Intake Unit (CIU) at a site approved by the Government.

B. The contractor/grantee shall require that each participating program submit criteria to be used for admissions and terminations.

C. The contractor/grantee shall make available a Central Intake Unit to provide uniform, standardized initial patient orientation, multi-phasic health screening and referral to an appropriate treatment modality for new and readmitted patients.

D. The CIU shall provide at least the following and such other items of patient care as may be prescribed by the Government:

1. A central intake facility for patients to remain open no fewer than 5 days per week, and no fewer than 8 hours per day.

2. A facility maintained in clean, safe and attractive condition and in accordance with appropriate local, state and Federal codes and other laws.

3. Appropriate furnishings for a central intake facility.

4. At intake, an initial personal history, medical history, and drug history.

5. At intake a physical examination and laboratory examination performed by qualified personnel.

   Physical examination stressing infectious diseases, pulmonary, liver, cardiac abnormalities, dermatologic sequelae of addiction and possible concurrent surgical problems.

Laboratory examination, including the following:

a. Complete blood count and differential

b. Serologic test(s) for syphilis

c. Routine and microscopic urinalysis

d. Urine screening for drugs (toxicology)

e. SMA 12/60 or equivalent

f. Chest X-ray

g. Australian antigen, as appropriate

h. Sickle cell, as appropriate

i. Pap smear and gonorrhea culture, as appropriate

j. Tetanus toxoid, as appropriate

k. EKG and biological test for pregnancy, as appropriate

6. Services of a medical director licensed in the jurisdiction within which the CIU exists. He shall insure that the initial evaluation is appropriately performed and that medical needs of individual patients are properly assessed and treated/referred, as appropriate. Medical services shall include initial diagnostic work-up, identification of medical and surgical problems for referral to other treatment facilities, and review of patient's records. The physician should, when appropriate, request a copy of the patient's previous medical records and forward them to the appropriate treatment center.

7. A formal written agreement between the CIU and a licensed hospital or hospitals in the community for provision of emergency, inpatient and ambulatory hospital services as appropriate. Such services will not be paid for under this contract/grant.

8. Interview of each new admission or readmission shall be performed by a mental health professional or by a qualified intake counselor under the supervision of the former. The intake staff shall take a complete personal history--family, education, vocation, legal and related areas, drug history, including kinds of drugs abused, when begun, and prior treatment attempts. The staff shall then present the various treatment modalities available for the patient. After

discussing these in light of the patient's particular situation (including the results of the physician's evaluation), a treatment modality shall be selected by mutual agreement with the applicant and the appropriate referral made.

9. A patient index of all drug dependent individuals referred for treatment through its screening and referral unit must be maintained. This index shall be updated by the participating agencies as transfers to other programs and termination occur.

10. The CIU must have the capability of referring a drug dependent individual with duplicate intake records to an appropriate treatment modality within 48 hours.

11. Uniform intake procedures must be established so that it will not be necessary for programs which receive patients from the CIU to duplicate services.

12. Urine surveillance according to the following procedures:

    Urine specimens from each patient must be collected under appropriate supervision during the intake process. The specimens must be analyzed for morphine, methadone, cocaine, codeine, amphetamines, barbiturates, as well as other drugs if indicated. Breath analysis is acceptable for alcohol testing.

    Laboratories used for urine testing must comply with all state and Federal proficiency testing programs.

E. If methadone is to be administered at the Central Intake Unit, the CIU must comply with the regulations of the Food and Drug Administration and also must function in compliance with all other relevant Federal and state regulations and guidelines.

F. Each CIU shall establish an approved patient record-keeping system adequate to fulfill state and Federal reporting requirements.

G. Each CIU shall establish and have evidence of formal agreements between the CIU and community-based drug treatment programs, documenting the program's agreement to utilize the CIU for patient intake functions and not to duplicate those functions; and to accept only patients who have been processed through the CIU.

H. Each CIU shall define: The procedures by which applicants shall be oriented to available treatment options; the decision-making process for determining recommended referral; the decision-making process for "mutual agreement" between applicants, programs, and CIU staff regarding referral; and procedures for meeting the needs of patients referred to the CIU for rescreening and re-referral to a more suitable modality or program. These shall be subject to state and Federal approval.

Exhibit 2

RESIDENTIAL DRUG-FREE

COMMUNITY BUDGET

Drug-Free Residential Community Budget

A. Personnel		
Administrator	$ 15,000	
Secretary	$ 8,000	
One Supervisory Counselor (in-residence)	$ 12,000	
Eight Counselors at 9,000 each	$ 72,000	
TOTAL	$107,000	
Employee Benefits 10%	$ 10,700	
Total Personnel Costs	$117,700	$117,700
B. Consultants		
Psychiatric (3 hr/wk @ 40/hr)	$ 6,240	$ 6,240
C. Travel		
Local for staff (auto & upkeep)	$ 3,200	
Local for clients	$ 728	$ 3,928
D. Equipment	$ 7,220	$ 7,220
E. Intake Medical Examinations		
1.6 dynamic to static capacity X 30 clients X $75 per exam	$ 4,050	$ 4,050
F. Other		
Utilities & Communication	$ 4,800	
Rent ($300/month)	$ 3,600	
Renovations	$ 10,000	
Food ($2.20/client/day)	$ 24,893	
Training	$ 500	
*Laboratory Services Contract	$ 4,680	
	$ 48,473	$ 48,473
Total Cost of Program with 30 client static capacity	$187,611	$187,611

*Because of the low volume of tests, it is assumed that 30 tests per week will be conducted at a cost of $3.00 per test.

The total cost per client year is $6,254.

Exhibit 3

SAMPLE ORGANIZATIONAL CHART

ORGANIZATIONAL CHART–DRUG FREE RESIDENTIAL COMMUNITY

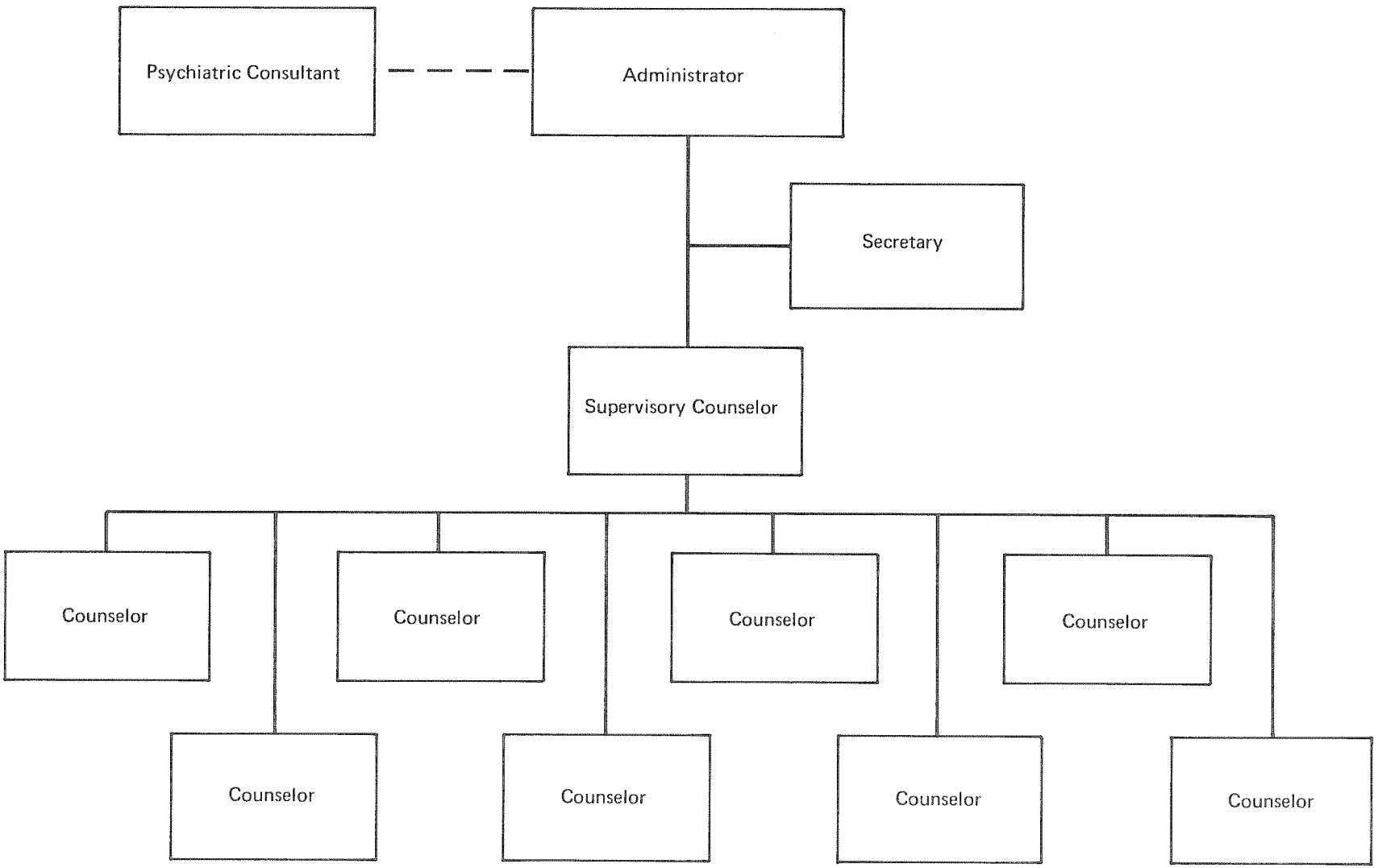

Exhibit 4

POSITION DESCRIPTIONS

A. Supervisory Counselor

Position Controls:

Incumbent works under the direct supervision of the administrator. The supervisor is available for assistance on unforeseen problems encountered. Work is reviewed for adequacy and compliance with instructions and available guidelines.

Duties and Responsibilities:

Supervises counselors in day-to-day client management. Independently assesses training needs of supervised staff and provides necessary training where feasible. In other instances, will report training needs to supervisor. Orients new personnel.

Conducts and/or provides individual or group therapy. Acts as therapy supervisor for counselor and provides on-going training in this area.

Along with the administrator, formulates therapy policy and participates in the revision. Acts as program supervisor in absence of the administrator.

Coordinates the drop-out and reentry programs and recreational activities within the program. Receives progress reports of same. Conducts treatment meetings in the absence of the administrator. May represent program in community meetings.

Attends professional meetings and conferences as approved by the administrator and performs other duties as assigned.

B. Counselor

Position Controls:

Receives general technical and administrative supervision from supervisory counselor. Assignments are well-defined and on-the-job training is given to develop counseling skills. Supervisor is available for assistance on unforeseen problems with instructions and available guidelines.

Duties and Responsibilities:

Collects supplemental information on designated clients using families, previous employers or co-workers, social and drug histories, and other sources as indicated for effective rehabilitation. Conducts orientation session for newly admitted clients.

Records all client activity at intervals designated by program policy. Maintains data on clients in organized, well-documented fashion and submits such documents to supervisory counselor for periodic review.

Prepares individual treatment plans for clients upon intake, revising these when necessary. Evaluates treatment plans at least every 30 days.

Can initially establish and, if assigned, supervise the day-to-day functioning of a departmental unit.

Advises supervisor of problems encountered in caseload management and recommends various approaches (e.g., increased privileges, increased counseling, disciplinary measures). Presents these in weekly treatment team meetings.

Participates in group and individual counseling, using supervisory counselor as resource for problem clients.

Communicates with other members of treatment staff continuously about significant behavior of all clients. Documents all contacts and/or contacts of other staff with clients. Is very observant of clients' behavior.

Attends professional conferences and meetings as directed.

Participates in urine surveillance assignments, submits urines upon request, and performs other duties as assigned.

C. Counselor Aide or Beginning Counselor

Position Controls:

Receives close technical and administrative supervision from an experienced counselor. Assignments are well-defined and on-the-job training is provided. Supervisor is available for assistance on unforeseen problems encountered. Work is reviewed and periodic discussions are conducted by supervisor as a part of incumbent's training. Guidelines include policy and procedural guides, and clinical case records and reports.

Duties and Responsibilities:

As directed by experienced counselor, may interview newly admitted clients and record data. Observes orientation groups for new clients, gradually assuming responsiblity for these groups.

Receives in-service training in interviewing techniques, program policies and procedures, and other areas to be applied in assignments. Participates in group and individual therapy as part of this training.

Establishes superficial relationships with clients designated as desirable by supervisor. Begins to utilize standard client management techniques as recommended by supervisor and as fit into program policy.

Performs other duties assigned and receives increased responsibility as indicated.

D. Vocational Rehabilitation/Job Development Counselor

Position Controls:

Works under the general supervision of the supervisory counselor. Technical supervision may be available from centralized vocational rehabilitation unit or the city vocational rehabilitation department. Work is reviewed by supervisory counselor and administrator.

Duties and Responsibilities:

Collects available social, educational, economic and vocational information on the resident which can be used in securing suitable employment. Contacts employment and social/civic service agencies in seeking employment for the resident. Is responsible for follow-up contact with prospective employers, and provides counselors with follow-up information. Conducts employment adjustment sessions with residents (e.g., resume preparation, promptness, etc.) to instruct them in applying for, winning, and maintaining a job.

Maintains good public relations and participates in team conferences and training with community agencies and local employment offices.

Maintains accurate records for statistical purposes of number of residents referred by counselors, number of residents referred to various agencies, employment retaining rates among residents, etc. Provides these to supervisory counselor upon request.

Keeps records collected on intake and updated periodically of employment needs, previous employment records, apprenticeships and skills of all clients, training needs, etc.

Participates in treatment team meetings.

Performs other duties as assigned.

E. Social Worker

Position Controls:

Works under direct supervision of supervisory counselor. Participates in intake interview. Elicits social history information. Conducts relatives group and seminars for residents on specific topics as appropriate.

Duties and Responsibilities:

Coordinates all treatment functions with outside agencies and screens inter-agency communications from counselor to these agencies (e.g., Division of Vocational Rehabilitation, Department of Public Welfare, hospitals, etc.). Initiates or supervises initiation of referrals for clients and follow-up.

Attends professional meetings and conferences as approved by administrator.

Participates in treatment team meetings.

Performs other duties as assigned.

Exhibit 5

SAMPLE TRAINING AIDS

- Philosophy and Concepts
  - Behavioral and Attitudinal Changes
  - Self-help
  - Self-awareness
  - Love and concern
  - Truth and honesty
  - Staff/client relationship
- Roles and Responsibility of Staff
- Roles and Responsibility of Residents
- Therapy
  - Individual sessions
    - Purpose and types of material handled
  - Group sessions
    - Purpose and types of material handled
      - Morning or community meeting
      - Seminars
      - Encounters or therapy groups
      - Supportive groups or probes
      - Family therapy or Relatives groups
- Recreation
- Educational Opportunities
- Vocational Rehabilitation
- Free Time

Client Management

Objectives: – To provide forum for discussion of program policy regarding client management.
– To provide staff with basics of effective management tools for addicts in treatment.

Points for Discussion:

A. Intake process

1. Elements
2. Duration
3. Staff

B. Client assignment and orientation

C. Recordkeeping

1. CODAP Standards
2. Individual program policy

D. Client types

Anger

Discussion points:

1. Angry clients are often resistant to their own feelings.
2. Carefully structure questions about the *source* of the anger. Otherwise, client may become further infuriated.
3. Attempt to point out area where client has directed immediate anger and deal from there.
4. Do not try to get at all causes of anger—especially if some have already been expressed. This minimizes those problems.
5. Do not give client the impression that you are avoiding his behavior.

Fear

Discussion points:

1. Avoid giving unsolicited advice.
2. Try to get client to explore feelings about a given situation.
3. Time your responses; avoid premature, investigating questions.
4. Explore possibilities to resolve conflict.

Anxiety

Discussion points:

1. Use approach that is sensitive to client's feelings.
2. Make responses emphasize sensitivity to feeling rather than content of conversation.
3. Attempt to continuously get information which adds to material already discussed.
4. Deal in the here and now if information about the past can be gathered later.
5. Avoid trying to resolve issue during the first interview.

E. Counseling

1. Individual

a. Assist client in taking risks. Help him discard old familiar ways of responding because he thinks they are safe.
b. Avoid stereotype labels. These allow the client to shift responsibility for his actions to the condition the label implies (i.e., dependent).
c. Assist clients in identifying his own faults instead of encouraging him to identify to society's.
d. Avoid comparisons (husband-wife; brother-sister, etc.) These allow the client to maintain a poor concept of himself and come out second best. Another excuse for irresponsibility.
e. Define client's fears with him. Do not allow him to bring up previous defeats as a motive for not venturing ahead.
f. Avoid (whenever possible) argumentative episodes with the client. He may often use this defense to prevent you from probing deeper areas.
g. Discourage client from blaming his past for his present behavior.
h. Attempt to define various client-defenses (i.e., clients with marital problems are often engaged in numerous activities to avoid admitting they may be lonely).
i. Note positive behavior.
j. Discard illusion that only you have problems.
k. Develop alternatives.
l. Avoid false accusations.

2. Groups (Residential setting)

a. Encounter

- Utilizes confrontation (attack) approach.
- Emphasizes behavior occurring in the here and now.
- Anger is openly expressed and dealt with.
- Leader assumes directive role.

b. Non-authoritarian (Tavistock Model)

- Forces members to assume responsibility; no "leader" scapegoat.
- Content centers around here and now.
- Leader assumes unattainable role, responses are limited to interpretations, provides little overt direction to the group.
- Not strongly recommended for new admissions.

c. Supportive

- Soft pedals hostility, anger and anxiety.
- Emotions are accepted, atmosphere is one of openess.
- Leader is compassionate, empathetic, directive; may even defend certain members.
- Recommended group type for amphetamine abusers.

d. Re-entry

Exhibit 6

SAMPLE COUNSELING RECORD

Sample Counseling Record

PROGRESS NOTES

NAME: Jane C. Doe

ID. NO.: 392

ENTRY DATE: 11/29/72

Date	Appt. Scheduled	
11/29/72	12/10/72 at 10:30 A.M. Mr. Jones, Vocational Rehabilitation	Jane C. Doe, a 33-year old white female, states that she has been abusing heroin since 1965 and has attempted to detoxify in several programs in New York City. She moved here one year ago after splitting with her husband. She now lives with her mother and two children. Ms. Doe is having problems with her current living situation (fights constantly with mother), and is unable to find or hold a job that interests her. Since her prior attempts at detoxifying and remaining drug-free on her own have failed, Ms. Doe feels residential drug-free would help her. She has just completed the 21 day detox program at Memorial Hospital. She is familiar with T.C.'s in New York and seems to have a good understanding of what T.C. treatment is about. Furthermore, Ms. Doe's mother is willing to keep the children during her time here so she is free to begin as soon as possible. Treatment Plan Twice weekly supportive groups Daily orientation group for first week Urine twice weekly Relatives group for mother once a week Individual counseling once a week Emphasis on vocational rehabilitation (first appointment with vocational rehabilitation specialist on 12/10/72). Will work intensively in this area. First confrontation group set for 2 weeks from now (12/15/72). Depending on reaction, will participate twice a week. Initial assignment to Housekeeping Dept. Short-term goals: vocational assessment and job training. Long-term goals: Working out problem with mother and children so she can responsibly care for children. Spent 1 hour with Ms. Doe. James Harris
11/30/72		Ms. Doe moved into the residence today and began an orientation group at 11 a.m. Mrs. Faulkner has been assigned to her as a big sister and will introduce her to her duties in the housekeeping de-

		partment. Ms. Doe will participate in a supportive group this evening which I will conduct. She expressed her commitment to treatment, but may be using it to escape her mother and children. Spent 25 minutes with Ms. Doe. James Harris
12/1/72		Ms. Doe appeared very frightened in the supportive group, but did manage to talk about her sense of responsibility and feeling of resentment toward her children. After her description, the group devoted about 15 minutes to her problem and suggested that one of her major reasons for entering the T.C. was to escape her responsibilities in that area. Ms. Doe's mother is scheduled to participate in a relatives group this week and the group leader is going to raise the same issue with her. Ms. Doe requested a half hour this afternoon to discuss her feelings toward her children. I plan to give her that time. After talking to Ms. Doe about her children, it appears that a great deal of work has to be done here. We decided to work it out in the group as far as possible and will not get involved on an individual basis for at least another two weeks. James Harris
12/2/72		In the Relatives group tonight, Ms. Doe's mother said that she felt Ms. Doe entered the T.C. to avoid her and the children. The mother said Ms. Doe was irresponsible about the children and that the children would be much better off without her. The mother's hostility was very apparent and it appears she has undermined Ms. Doe's authority and role with her children. Ms. Doe likes the Housekeeping Department and according to the department leader is very conscientious about her duties there. She avoids extensive contact with the other residents and prefers to work by herself. The department leader is gradually pushing her to work with the others by making her part of a two man team with an older female resident. Ms. Doe continues to be obviously uncomfortable in the group setting and, unless directly confronted, will not react to what is happening. The group has picked up on this and is beginning to focus its attention on her non-participation. Urine taken today. James Harris
12/3/72		Ms. Doe is responding to her team partner's efforts to draw her out during housekeeping although she continues to behave in a passive way. During the group tonight, Ms. Doe reacted strongly to constant questions by crying and eventually screaming at the other group members. She accused them of treating her like her mother and pushing her around. She blamed her mother for her need to use heroin and stated that her mother broke-up her marriage and is stealing her children from her. The group responded by asking her to

		describe how her mother did this. Ms. Doe discussed her life for the next 15 minutes. Feelings of worthlessness and inability to control what happened to her came out. Her aggressive attitude turned into self-pity. At this point, the group first supported some of her feelings by describing their past experiences with overbearing mothers and then talked about how they overcame their own lack of self-esteem by standing-up to others in less emotionally significant relationships. The group suggested that Ms. Doe begin by resolving to speak out during housekeeping and give her opinion on how to approach certain tasks. Ms. Doe tried to apologize for her outburst but the group refused to take it. Ms. Doe was confused by this but said it made her happy, although she didn't know why. James Harris
1/3/73		Monthly Evaluation: Although Ms. Doe abused drugs sporadically three times during first month in treatment, she shows signs of positive adjustment. She now participates openly in groups and appears to be responding particularly well to the Supportive Group. She recognizes that her mother is not an acceptable scapegoat for her own behavior and understands that she has some control over her own life. The Encounter Group should reenforce this understanding. Ms. Doe's vocational test results show that she likes and has some skill in bookkeeping. Mr. Jones of DVR has a training slot for her in a bookkeeping/accounting program beginning in February. While Ms. Doe will be assigned to the Seminar Department beginning 1/5, she will be moved to Business Administration once the vocational program begins. Because of her sporadic drug use, she will now give up three urine specimens per week. Individual counseling will be limited to once every other week in order to reenforce the group process. If her mother's attitudes as expressed in the relatives group continue for the next month, I will confer with the psychiatrist about possible alternative approaches to use with her in the context of the relatives group. James Harris

Exhibit 7

SAMPLE INTAKE FORM

CENTRAL MEDICAL INTAKE FORM I

Patient Routing Card

Patient name: _____ I.D. # _____

CMI Counselor _____ CMI Date _____

☐ Voluntary ☐ CJS ☐ Transfer _____

☐ Complete New or Re	☐ Partial Re	☐ Annual P.E.
☐ Clerk	☐ Clerk	☐ Clerk
☐ Blood	☐ Urine (drugs)	☐ Blood
☐ Urine (Complete)	☐ Rx update	☐ Urine (Medical)
☐ Medical Rx	☐ P.E. update	☐ Medical Rx
☐ Chest X-ray	☐ Other _____	☐ Chest X-ray
☐ Physical exam	_____	☐ Physical exam
☐ Footprint	_____	☐ Footprint
☐ Interview	☐ Interview	☐ Interview
☐ I.D. Card	☐ I.D. File	☐ I.D. File
Rec. Rx _____	Rec. Rx _____	Center _____
Center _____	Center _____	Time Out _____
Time Out _____	Time Out _____	

Comments _____

_____

CENTRAL MEDICAL INTAKE REPORT FORM III
MEDICAL HISTORY REPORT FORM

Patient Name: _____ Client No. _____

YES	NO	HAVE YOU EVER HAD:
____	____	Anemia or Blood Disease (Sickle Cell Disease)
____	____	Cancers or Tumors
____	____	Rheumatic Fever
____	____	Heart Disease
____	____	Varicose Veins
____	____	Phlebitis or Infected Veins
____	____	Tuberculosis
____	____	Pneumonia or Pleurisy
____	____	Asthma
____	____	Hay Fever
____	____	Sinus Trouble
____	____	Allergy to Drugs or Foods
____	____	Hives
____	____	Dermatitis or Skin Disease
____	____	Eye Infection
____	____	Blindness
____	____	Color Blindness
____	____	Deafness or hearing loss
____	____	Seizure disorders or epilepsy
____	____	Severe back disease
____	____	Arthritis or Joint Disease
____	____	Stomach ulcers or ulcer disease
____	____	Gall bladder disease
____	____	Diabetes
____	____	Thyroid disease
____	____	Syphilis – date_____ Where treated_____
____	____	Gonorrhea
____	____	Hepatitis
____	____	Hypertension or High Blood Pressure
____	____	Malaria
____	____	Kidney disease
____	____	Typhoid fever
____	____	Gout
____	____	Hemorrhoid

What other diseases not on this list have you had:

1. _____
2. _____
3. _____
4. _____

When did you have your last regular physical examination _____
When did you last see your dentist _____
Where are your most recent medical records _____
Are your teeth in good repair currently _____
Do you wear eye glasses or contact lenses _____
Do you need new eye glasses _____

Patient Name _____ Client No. _____

How many times have you been hospitalized _____
For more than 24 hours (include all operations, OB & GYN) _____

Name Hospital _____ Date _____ Disease _____
Name Hospital _____ Date _____ Disease _____
Name Hospital _____ Date _____ Disease _____
Name Hospital _____ Date _____ Disease _____

Indicate Health Status: Excellent _____ Good _____ Fair _____ Poor _____

Name of personal physician or clinic _____
Address _____ Telephone _____
Medicaid No. _____ Card Color _____
Hospitalization No. _____

HAVE YOU RECENTLY:

Yes	No	
___	___	Had a sore tongue
___	___	Had "fever sores"
___	___	Had difficulty swollowing
___	___	Had excessive gas
___	___	Had abdominal pain
___	___	Been constipated often
___	___	Had diarrhea frequently
___	___	Had blood in your bowel movements
___	___	Had black bowel movements
___	___	Had light gray or white bowel movements
___	___	Had burning or discomfort when you urinate
___	___	Had very dark (green-brown) urine
___	___	Had stiffness, swelling or pain in your joints
___	___	Had frequent or severe headaches
___	___	Had persistent numbness or weakness any place in your body
___	___	Had dizziness or light-headedness
___	___	Had unsteadiness in walking or balance
___	___	Had difficulty falling or staying asleep
___	___	Felt tired after having enough sleep
___	___	Had difficulty remaining awake during usual waking hours
___	___	Felt excessively tired or weak
___	___	Had any trouble with skin sores
___	___	Had excessive itching
___	___	Gained or lost 5 pounds of weight or more
___	___	Had any chills or fever
___	___	Had any difficulty with your vision
___	___	Been troubled with double vision
___	___	Had a buzzing or ringing in your ears
___	___	Had severe nose bleeds
___	___	Had difficulty breathing through either side of your nose

Patient Name _____ Client No. _____

HAVE YOU RECENTLY (continued)

Yes	No	
___	___	Had any hoarseness
___	___	Had a bad cough
___	___	Had night sweats
___	___	Felt short of breath easily
___	___	Noticed anything unusual about your heart beat
___	___	Had pain in your chest
___	___	Had hand swell
___	___	Had cramps while walking
___	___	Had a loss of appetite
___	___	Had nausea or vomiting
___	___	Had bleeding gums
___	___	Do you have unusual thirst or hunger
___	___	Had feet or ankles swell

Yes	No	Don't Know	
___	___	_____	Are you very shy or sensitive
___	___	_____	Are your feelings easily hurt
___	___	_____	Are you easily restless
___	___	_____	Are you nervous or "keyed up" most of the time
___	___	_____	Is it difficult for you to relax
___	___	_____	Are you easily irritated and upset
___	___	_____	Are you often depressed or blue
___	___	_____	Do you cry easily
___	___	_____	Do you have any unusual fears
___	___	_____	Have you had nightmares
___	___	_____	Do you worry very much
___	___	_____	Do you regard yourself as being nervous
___	___	_____	Have you ever been examined or treated for a nervous illness
___	___	_____	Have you ever had a nervous breakdown
___	___	_____	Are there any sexual matters or difficulties you would like to discuss
___	___	_____	Have you been married more than once
___	___	_____	Do you have any work problems which produce emotional stress
___	___	_____	Do you enjoy school work
___	___	_____	Do you enjoy on-job-training

I hereby give my consent for the following:

1. A physical examination
2. A blood test for blood chemistries and syphilis
3. Urinalysis to screen for abnormalities and drug content
4. Chest X-ray
5. Pregnancy test (female only)

I also understand that if my syphilis test or X-ray indicate the presence of communicable disease, the results will be released to the Department of Public Health for further confidential follow-up.

_____

Signature and Date

FOR FEMALES ONLY

Patient Name: _____ Client No. _____

Age of your first period _____
Is your period regular _____
Period occurs every _____
Usual flow: Normal _____ Heavy _____ Light _____
Has there been an: Increase ( ) Decrease ( ) in flow recently
Date of last normal period _____
Are you tensed or irritable before or during periods _____
Have you, within the past year, had vaginal bleeding other than at the time of your period _____
Are you or do you think you are pregnant _____
Age of first pregnancy _____ Number of living children _____
Date of Birth _____
How many Abortions _____ Dates _____ Miscarriages _____ Dates _____
Stillbirth _____ Dates _____
Do you feel you have an unusual amount of vaginal discharge or itching _____
Note: If you have ever been treated for a female disorder or been told you had any trouble with your female organs list here _____
Do you have hot flashes _____
Have your breasts recently changed in size _____
Have you recently had any breast discharge _____
When was your last pelvic (GYN or Vaginal) examination _____
Are you on birth control pills _____
What kind of pill _____ How long _____

* *

PROGRAM ON METHADONE IN MOTHERS AND INFANTS

Patient Name: _____ Referred by _____
ID No. _____ Date of referral _____
Date of Birth _____ Marital status ( ) M ( ) D ( ) Sep. ( ) W ( ) S
Address _____ with whom living _____
Telephone: Home _____ Work _____
For Emergency Contact _____
Name Phone
Employment current ( ) Yes ( ) No Date begun _____
Highest grade completed _____ Medicaid ( ) Yes ( ) No ( ) Eligible
Other Insurance _____
Length Heroin use _____ length present habit _____ other drug use _____
_____
clinic patient attends _____
Counselor _____ Nurse _____
Treatment received: Meth. Maint. _____ Detox _____ Other _____
Date Rx begun _____ ended _____
Prenatal care at clinic _____ Hospital _____ Private _____
Name
None _____ Date begun _____
Patient to deliver at _____
Expected date of confinement _____
Referred to _____

Exhibit 8

CONFIDENTIALITY REGULATIONS

federal register

THURSDAY, DECEMBER 6, 1973
WASHINGTON, D.C.

Volume 38 ■ Number 234

PART IV

SPECIAL ACTION OFFICE FOR DRUG ABUSE PREVENTION

■

CONFIDENTIALITY OF DRUG ABUSE PATIENT RECORDS

Title 21—Food and Drugs

CHAPTER III—SPECIAL ACTION OFFICE FOR DRUG ABUSE PREVENTION

PART 1401—CONFIDENTIALITY OF DRUG ABUSE PATIENT RECORDS

In the FEDERAL REGISTER of November 17, 1972 (Vol. 37, No. 223, pages 24636–24639), a new Part 401 was added to Title 21 of the Code of Federal Regulations entitled "Confidentiality of Drug Abuse Patient Records." (37 CFR 401). This part was promulgated as an interpretative regulation to deal comprehensively with both substantive and procedural problems which had arisen under section 408 of Public Law 92–255 (21 U.S.C. 1175), the Drug Abuse Office and Treatment Act of 1972.

By order published in the FEDERAL REGISTER on September 24, 1973 (38 FR 26111), Part 401, Chapter III of Title 21 of the Code of Federal Regulations was redesignated as Part 1401, Chapter III of Title 21 and §§ 401.01 through 401.73 therein were redesignated as 1401.01 to 1401.73, respectively. Accordingly, all references and changes herein relate to the numbered sections as redesignated rather than the numbered sections as originally published.

To provide information necessary to aid the Director of the Special Action Office for Drug Abuse Prevention in determining whether this regulation should be amended, revoked, or reissued, interested persons were invited to submit written data, views, and arguments. Numerous comments, suggestions, and recommendations were received from professional and other organizations and individuals as well as known authorities in the field of drug abuse treatment and rehabilitation. Without exception, the comments supported the underlying policy of protecting the privacy of patients in federally authorized or supported drug abuse prevention programs as a necessary step in reducing the incidence of drug abuse in our society.

The Special Action Office has given serious consideration to all of the comments, suggestions, and recommendations. Many of them could not be adopted without changes in section 408 of the act. Several were based on a misconstruction of the regulations and required no changes. Others raised questions regarding certain sections of the regulation which required clarification or changes. The Director has determined that all of the amendments, which are hereinafter set forth, are necessary or desirable in furtherance of the Government's policy of securing the privacy of patient records as an important part of its program of minimizing the adverse social consequences of drug abuse.

A summary review of the comments and recommendations and the action taken with respect to each are set forth below, followed by the full text of the regulation as revised.

1. *Definition of drug abuse prevention function.* Through inadvertence, the definition of "drug abuse prevention function authorized or assisted under provisions of the act or any act amended by the act" as appearing in § 1401.01 of the regulations, embraced only those programs which (1) are conducted by an agency or department of the United States Government or (2) are conducted by virtue of a license, permit, or other authorization from any such agency or department. It was intended that this definition also should include any drug abuse prevention function which is supported by any agency or department of the United States pursuant to Federal law. Section 1401.01 is so amended.

2. *Definition of medical personnel.* Under § 1401.01(g) the definition of "medical personnel" includes physicians, nurses, psychologists, counsellors, and supporting clerical and technical personnel. A recommendation has been made that this definition be clarified with respect to social workers and staff members in training positions. Section 1401.01(g) has been amended to make it clear that these persons are included in the definition, as well as to explicitly include financial and administrative personnel such as those processing insurance claims directly related to treatment.

3. *Definition of records.* Section 408(a) provides that: "Records of the identity, diagnosis, * * *" are to be kept confidential. The comment has been made that this section does not refer to "communications" and the question has been raised as to whether communications and other types of information were intended to be protected against unauthorized disclosures. While it is true that section 408 does not refer to "communications," it is obvious that the policy of the section would be defeated if drug treatment personnel were allowed to disclose communications or other unrecorded information received from the patient, whether or not they were permitted to disclose the records based upon such communications. Any other interpretation would defeat the principal objective of section 408 in attempting to encourage drug addicts to volunteer in a drug treatment program. We have construed section 408 as applying not only to "records" but also to all communications and other information relating to the patient's identity, diagnosis, prognosis, or treatment in a federally authorized or supported drug abuse prevention activity. Therefore, if information would be treated as confidential if recorded, it should receive the same protection if not recorded. Paragraph (h) of § 1401.01 has been added to express this interpretation.

4. *Applicability prior to March 1, 1972.* An inquiry has been received as to whether section 408 applies to records in existence prior to the publication of the regulations or the enactment of the statute. Section 408 of P.L. 92–255 applies to records "maintained in connection with the performance of any drug abuse prevention function authorized or assisted under any provision of this act or any act amended by this act." This is implemented by § 1401.02 which makes section 408 applicable to records made on or after March 21, 1972, the date of enactment of P.L. 92–255. Therefore, provisions of section 408 would apply to any records of a patient generated after March 21, 1972. Also, they would apply to all records of a patient generated prior to March 21, 1972, provided he was an active participant in a treatment program on that date and such participation represented a single continuous program. Therefore, the record of a patient actively participating in a federally authorized or supported drug abuse prevention program on March 21, 1972, should be considered as confidential in its entirety even though part of it was generated immediately prior to that date. Section 1401.02(a) of the regulations is amended to clarify this point.

5. *Disclosure to governmental personnel for purposes of obtaining benefits.* Section 1401.23 provides for disclosure with the patient's consent for the purpose of obtaining public benefits. A recommendation has been made that limitations should be set upon the nature and extent of the information legitimately needed to qualify for benefits. In effect, the patient already has the right to limit the extent of disclosure for purposes of obtaining these benefits. Section 1401.06 limits disclosure to information necessary in the light of the need or purpose for the disclosure and under § 1401.21, the patient in granting consent, must specify the type of information to be disclosed. In view of the restrictions in these two sections, no further limitations are deemed necessary in § 1401.23.

6. *Disclosure in connection with judicial or administrative proceedings.* Section 408(b)(1)(B) permits a patient to consent to disclosure to governmental personnel for the purpose of obtaining benefits to which the patient is entitled. Numerous questions have been raised concerning the authority of a patient to consent to a disclosure in a judicial or administrative proceeding which involves an issue relating to a patient's claim, benefit, or a right to which the patient is entitled. Under § 1401.24, similar disclosures are authorized in connection with parole, probation, or suspension of prosecution. To clarify this question, a new paragraph (d) has been added to § 1401.23. This section provides that whenever a patient is entitled to any claim or other benefit which is an issue in any judicial or administrative proceeding and some part or all of his drug abuse record is relevant to, and necessary in support of, such claim or benefit, such patient may consent to disclosure of his record to the extent needed to support such claim or other benefit. When any such disclosure is authorized, the court, administrative tribunal, or other governmental body or official should be alerted as to the need to maintain confidentiality and to avoid, to the extent practicable, any further disclosure of the record or the patient's identification.

7. *Evaluation of employment data for purposes of rehabilitation.* Section 408(b)(1)(B) of Public Law 92–255 (21 U.S.C. 1175(b)(1)(B)) permits disclosure with the patient's consent "to government

personnel for the purpose of obtaining benefits to which the patient is entitled." Section 101 of the Act contains an express finding that the success of Federal drug abuse programs and activities requires a recognition that education, treatment, and rehabilitation are interrelated. Section 103(b) defines "drug abuse prevention function" as any program relating to education, training, treatment, rehabilitation or research and includes "any such function even when performed by an organization whose primary mission is in the field of drug traffic prevention functions or is unrelated to drugs." The Director of the Special Action Office has determined that employers, employment agencies and employment services which have demonstrated their willingness to assist in the employment of persons who are present or past patients in a drug abuse treatment or rehabilitation program are performing an essential drug abuse prevention function. Section 1401.26 now provides that an evaluation of patient's progress or status in a treatment program may be furnished to an employer but only after the patient has been employed or has been accepted for employment. This section is now revised to permit limited disclosures to employers and employment agencies and services which have agreed to assist such patients, both present and past, in obtaining gainful employment. Disclosure is permitted only with the patient's consent and is limited to an evaluation of such patient's status or progress in treatment or rehabilitation program. Section 1401.26 is amended accordingly.

8. *Consent of a minor patient to disclose to parents.* Two questions have been raised concerning the disclosure of the records of a minor patient to his parents. The first question concerns the authority for such disclosure. The second question inquires as to whether a minor patient is authorized to give consent. The answer to the first question is set forth in § 1401.26(b) of the regulations. This section provides that information in the nature of a general evaluation of a patient's present or past status in a treatment program may be furnished to members of the patient's family if, in the judgement of a qualified physician or counsellor, such information would be helpful in the treatment or rehabilitation of the patient and the patient makes a written request that such information be furnished. It should be noted that this provision is limited to the disclosure of a mere evaluation of the patient's status or progress in a treatment program and also can only be done if requested by the minor.

Regarding the second question, whether a minor would have authority to consent to disclosure where otherwise permitted, the answer to this question would depend upon local law in view of the fact that section 408 establishes no specific rule on the question. Of course, if the minor is considered incompetent under local law, consent can then be rendered by a guardian or conservator or if deceased by his personal representative as provided in § 1401.04. However, this would apply only in cases where disclosure is otherwise authorized with patient's consent under section 408 or the regulations.

Neither of these comments require any change in the regulations since they have been dealt with already to the extent permissible under law. Therefore, no revisions are considered necessary.

9. *Health and other insurance claims.* There have been numerous instances in which patients, or former patients in a drug abuse prevention program, have encountered difficulty in supporting their claims for reimbursement or payment under health or other insurance arrangements or programs under which they are beneficiaries. A major cause of this difficulty is attributable to the reluctance of drug abuse programs to disclose the necessary information from the patient's record to support the claim notwithstanding the fact that any such payment or reimbursement is directly related to the patient's treatment, which is part of the definition of "drug abuse prevention function" in section 103(b) of Public Law 92–255. Therefore, in order to clarify the law governing records pertaining to such claims, a new § 1401.27 has been added specifically authorizing a limited disclosure of information in a patient's record with his consent to the extent necessary to support a claim for payment or reimbursement under a health or other insurance program for the benefit of the patient and under circumstances in which such claim is related to the performance of a drug abuse prevention function, i.e., treatment or rehabilitation.

10. *Disclosure to a registry.* Section 1401.43 of the regulations permits disclosure among programs and to a registry serving such programs. It has been suggested that the regulations should spell out the extent of supervision necessary for the maintenance of a registry. Otherwise, it has been argued, the potential for abuse of a centralized listing of persons so closely affiliated with illicit behavior could undermine the basic policy of confidentiality in section 403. Section 1401.43 is intended to permit the operation of a central intake facility to prevent simultaneous registration in more than one methadone program and to assure that potential patients are made aware of vacancies in any participating programs. Such a registry is simply an extension of the treatment program and since the registry is prohibited from making any disclosure except as authorized under section 408 and the regulations, there is adequate protection of the privacy of patients against unauthorized disclosures. Moreover, the information which can be collected or retained by such a registry is strictly limited to that which is necessary to the performance of its functions. Therefore, the Special Action Office deems it unnecessary to specify additional limitations at this time.

11. *Research, audits and program evaluations.* Referring to the fact that section 408(b)(2)(B) authorizes disclosure without the consent of the patient to "qualified personnel" for the purpose of conducting scientific research, management or financial audits or program evaluations, it was noted that § 1401.44 of the regulations does not offer any guidance as to what persons come under the classification of "qualified personnel."

"Qualified personnel" under section 408(b)(2)(B) of the act applies principally to two groups. The first group includes personnel making management or financial audits and program evaluations. Except in special circumstances, these functions would be performed only by Federal, State, or local governmental licensing, regulatory, or accrediting agencies which have oversight or other official responsibility with respect to such functions. The second group includes personnel conducting scientific research or evaluations. This group would include principally individuals, groups or organizations having primary responsibility for the collection, evaluation, and dissemination of information in connection with a scientific or program evaluation study for which actual drug abuse data is needed. Paragraph (b) has been added to § 1401.44 to define "qualified personnel" as used in section 408(b)(2)(B).

12. *Disclosure to State agencies as required by statute.* Several comments have been made that State statutes, in many instances, require a disclosure to the State Public Health Department or other State boards or agencies to carry out some local policy objective, such as a check on doctors to determine possible abuse in the treatment of drug addicted patients. Apparently, some doubt has been expressed that section 408 and the regulations do not cover this situation. Attention is directed to § 1401.44 which authorizes disclosure without the consent of a patient to qualified personnel for purposes of conducting scientific research, management audits, financial audits, or program evaluations. To the extent that personnel of State agencies or boards are serving some legitimate objective related to one of the purposes indicated in this section, disclosure to such personnel would seem to come within the intent of section 408(b)(2)(B) of Public Law 92–255 and § 1401.44 of the regulations. Attention is specifically invited, however, to the fact that section 408(b)(3)(B) protects the patient in that any qualified personnel receiving patient information is prohibited from disclosing, directly or indirectly, the identity of any individual patient. If any State law provided otherwise, the Federal policy as set forth in section 408(b)(2)(B) would prevail. Consequently, if the State personnel involved meet the qualifications test by reason of conducting scientific research, management or financial audits or program evaluations and they remain subject to the policy in section 408 with respect to further disclosure, in most instances disclosure to such personnel is authorized. However, a program director need not authorize a disclosure under section 408

(b)(2)(B) if he does not have assurance that the patient's rights of confidentiality are respected. It is believed, therefore, that a reasonable interpretation of this section will accommodate most problems that might arise thereunder and therefore no changes are being made at this time.

13. *Disclosure in court proceedings—court orders.* Several questions have been raised regarding disclosures in court proceedings and the procedure and authority for making such disclosures in certain situations.

(a) One comment referred to a situation in which the drug addiction of the husband was a ground for divorce and therefore was relevant to a proceeding for divorce initiated by the wife. Assuming other evidence is not available, the proper procedure in such a case would be to obtain a court order under section 408(b)(2)(C) based upon a showing of good cause. This would be done under § 1401.72 of the regulations and the court should be asked to receive the evidence in camera.

(b) Another question related to the lack of a requirement of notice to the patient and an opportunity to participate in a court proceeding under section 408(b)(2)(C) of the act. This question raised the issue that due process should require an opportunity to participate in what may be a critical stage of a criminal proceeding, otherwise the proceedings would be ex parte with only the applicant and the judge present. The further comment is made that the regulations contain no definitional guidance as to what constitutes the "public interest" in the granting of a court order and recommends that more specific guidance be included in any revision of the regulations. Attention is invited to § 1401.72 which sets forth information which should be included in an application for a court order under section 408(b)(2)(C) of the act. This information is intended to assist the court in making a finding as to whether disclosure in any particular case would be in the public interest. Until there is compelling evidence of a need to provide further clarification, the Special Action Office deems it undesirable to make additional changes on these points.

(c) A related comment suggests that section 408 requires that the court consider the possible injury to the patient and to the physician-patient relationship in any proceeding to determine whether an order should be granted in the public interest. It is indicated that in any such proceeding the identity of the patient will be disclosed and information concerning him as a patient will be the subject of discussion at the hearing and consequently in effect would constitute a damaging disclosure in violation of the intent of section 408. This is a valid comment but it assumes that the patient's identification will be disclosed at the hearing. Counsel, as well as the court, should be alerted to the dangers of such disclosure in order to avoid the identification of a specific patient as the subject of the hearing. This can be done by an agreement between counsel and the court that the patient's name will not be identified in the proceedings. Also, whenever it will serve the interests of justice, disclosure should be made in camera and the record sealed.

In view of the foregoing recommendations, it is hereby found that good cause exists to make the amendments in the regulation as described above. It is hereby determined that good cause exists to make these amendments effective immediately, that such amendments constitute interpretative rules within the meaning of section 553(b) of title 5, United States Code, and accordingly that notice and public procedure thereon prior to their effectiveness are not required by law. Therefore, it is ordered that title 21, Chapter III, Part 1401 of the Code of Federal Regulations be amended accordingly and as amended will read as hereinafter set forth, effective upon publication in the FEDERAL REGISTER.

By order of the Director of the Special Action Office for Drug Abuse Prevention, November 29, 1973.

GRASTY CREWS II,
General Counsel.

GENERAL PROVISIONS

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INTERPRETATION OF SECTION 408(b)(2)(C) IN RELATION TO OTHER LAWS

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1401.62 Scope of orders; relationship to confidentiality provisions of Public Law 91-513.

INTERPRETATIVE GUIDELINES FOR APPLICATIONS AND ORDERS UNDER SECTION 408(b)(2)(C)

1401.71 Applications for orders should be restricted to records of specified patients.
1401.72 Information which should be furnished in support of application.
1401.73 Suggested safeguards against unnecessary disclosures.

AUTHORITY: The provisions of this Part 1401 are authorized under sections 213, 221, 222, and 408 of the Drug Abuse Office and Treatment Act of 1972 (Public Law 92-255; 21 U.S.C. 1122, 1131, 1132, and 1175), and other relevant provisions of law.

GENERAL PROVISIONS

§ 1401.01 Definitions.

For the purposes of this part, the following words shall have the meanings indicated:

(a) The term "Act" means the Drug Abuse Office and Treatment Act of 1972 (Public Law 92-255) including such amendments thereto as may be in effect at the time the provision referring to it is applied.

(b) The term "Director" means the Director of the Special Action Office for Drug Abuse Prevention.

(c) The term "drug abuse prevention function" means any program or activity relating to drug abuse education, training, treatment, rehabilitation, or research, and includes any such function even when performed by an organization whose primary mission is in the field of drug traffic prevention functions (as defined in 21 U.S.C. 1103(c)), or is unrelated to drugs.

(d) The term "drug abuse prevention function authorized or assisted under any provision of the Act or any act amended by the Act" means any drug abuse prevention function—

(1) Which is conducted or supported, in whole or in part, by any department, agency, or instrumentality of the United States, or

(2) For the lawful conduct of which in whole or part any license, permit, or other authorization is required to be granted by any department or agency of the United States.

(e) The term "patient" means any person who is or has been interviewed, examined, diagnosed, treated, or rehabilitated in connection with any drug abuse prevention function and includes any person who, after arrest on a criminal charge, is interviewed and/or tested in connection with drug abuse preliminary to a determination as to eligibility to participate in a drug abuse prevention program with the approval of the court.

(f) The term "governmental personnel" means those persons who are employed by the U.S. Government, by any State government, or by any agency or political subdivision of either, and includes Veterans Administration personnel as described in § 1401.23(b).

(g) The term "medical personnel" includes physicians, nurses, psychologists, counselors, social workers, and supporting administrative, financial, clerical, and technical personnel.

(h) The term "records" as used in section 408(a) shall include communications and other information, whether recorded or not, relating to the identity, diagnosis, prognosis or treatment of a patient.

§ 1401.02 Applicability.

(a) Except as provided in paragraph (b) of this section, this part applies to records or any part thereof made on or

after March 21, 1972, of the identity, diagnosis, prognosis, or treatment of any patient which are maintained in connection with the performance of any drug abuse prevention function authorized or assisted under the Act or any act amended by the Act. This part applies also to records maintained for patients actively participating in a treatment program prior to March 21, 1972 where such prior treatment is part of one continuous treatment activity still subsisting on that date.

(b) The provisions of section 408 of the Act (21 U.S.C. 1175) and the remaining provisions of this part do not apply to any interchange of records entirely within the Armed Forces, within those components of the Veterans Administration furnishing health care to veterans, or between such components and the Armed Forces, but otherwise such section and this part apply to any communication to or from any person outside the Armed Forces or such components of the Veterans Administration.

§ 1401.03 General rules regarding confidentiality.

Records of the identity, diagnosis, prognosis, or treatment of any patient which are maintained in connection with the performance of any drug abuse prevention function shall be confidential, may be disclosed only as authorized by this part, and may not otherwise be divulged in any civil, criminal, administrative, or legislative proceeding conducted by any Federal, State, or local authority, whether such proceeding is commenced before or after the effective date of this part.

§ 1401.04 Incompetent or deceased patients.

In any case in which disclosure is authorized with the consent of the patient, such consent may be given by a guardian, conservator, or other court-appointed designee in the case of an incompetent patient, and by an executor, administrator, or other personal representative in the case of a deceased patient.

§ 1401.05 Security precautions.

(a) Appropriate precautions should be taken for the security of records to which this part applies. The succeeding paragraphs of this section set forth examples of such precautions, but these should be added to or may be modified in the light of individual circumstances.

(b) The file of each patient maintained in connection with the performance of any drug abuse prevention function should be marked "Confidential Patient Information," as should any record identifying an individual as a drug abuse patient, including photographs, fingerprints, reports of skin abrasions indicating drug use, or other documentation of patient identification.

(c) Each file drawer, cabinet, or other container in which such files are kept should be conspicuously labeled with a cautionary statement such as the following:

CONFIDENTIAL PATIENT INFORMATION

Any unauthorized disclosure is a Federal offense.

§ 1401.06 Extent of disclosure.

Any disclosure made under this part, whether with or without the patient's consent, shall be limited to information necessary in the light of the need or purpose for the disclosure.

DISCLOSURES WITHOUT COURT AUTHORIZATION AND WITH CONSENT OF PATIENT

§ 1401.21 Form of consent.

(a) Where disclosure is authorized with the consent of the patient, such consent must, except as otherwise provided, be in writing and signed by the patient. Such consent must state—

(1) The name of the person or organization to whom disclosure is to be made,

(2) The specific type of information to be disclosed, and

(3) The purpose or need for such disclosure.

§ 1401.22 Disclosure to medical personnel.

With the patient's consent, disclosure to medical personnel is authorized for the purposes of diagnosis or treatment. The consent must be in writing and in the form prescribed in § 1401.21. All medical personnel to whom disclosure is made shall be subject to all of the rules on confidentiality as set forth in this part.

§ 1401.23 Disclosure to governmental personnel for purpose of obtaining benefits.

(a) *Benefits generally.* With the written consent of a patient, disclosure is authorized to governmental personnel for the purpose of obtaining benefits to which the patient is entitled. For the purposes of this section, benefits to which a patient is entitled include, but are not limited to, any welfare, medicare, or other public financial assistance authorized by Federal, State, or local law, the suspension of prosecution, the granting of probation or parole, public pension or retirement benefits, and any other benefit conferred by lawful authority.

(b) *Veterans benefits.* Disclosure may be made to Veterans Administration personnel for the purpose of determining a patient's eligibility for hospitalization, pension, or other veterans' benefits. For the purpose of this section, Veterans Administration personnel includes any personnel (whether or not employed or compensated by the Veterans Administration) authorized by the Veterans Administration to assist patients in the preparation and submission of their claims.

(c) *Welfare benefits.* Where treatment for drug abuse has been made a condition to the granting or continuation of a welfare or other public benefit, disclosure is authorized to governmental personnel responsible for the administration or determination of such benefits.

(d) *Claims or benefits adjudicated in judicial or administrative proceedings.* In any proceeding before a court, an administrative tribunal, or other governmental body or official having authority to approve or disapprove, or to recommend approval or disapproval, of a claim or other benefit to which a patient is entitled and all or some part of such patient's drug abuse record is relevant and necessary to the determination of such claim or other benefit, such patient may consent to, and authorize the disclosure of such record or portion thereof deemed necessary to support such claim or benefit. When any such disclosure is authorized, the court, administrative tribunal, or other governmental body or official should be alerted as to the need to maintain confidentiality and to avoid, to the extent practicable, any further disclosure of the record or the patient's identification.

§ 1401.24 Disclosure in connection with parole, probation, or suspension of prosecution.

(a) In the case of a drug abuser charged with a criminal offense or who is subject to parole or other probationary action and who has agreed to participate in a drug abuse prevention treatment program as a condition of release from confinement or as a condition to the dropping, deferral, or suspension of charges or judgment, disclosure of such person's treatment records in connection with such program is authorized if the patient consents in writing to participate in such program and consents to disclosure in accordance with § 1401.21.

(b) Disclosure pursuant to this section shall be limited to the patient's attorney and to governmental personnel having responsibility with respect to the prosecution of the patient or for supervising his probation or parole.

§ 1401.25 Disclosure to legal counsel.

(a) In any situation in which disclosure is permitted with the patient's consent for one or more of the authorized purposes as stated in this part and the patient has secured the advice of legal counsel, disclosure may be made to the patient's attorney upon the written application of the patient endorsed by the attorney.

(b) In any situation in which a patient seeks the advice of legal counsel on the question of waiving confidentiality, disclosure is authorized to the extent necessary to render such advice, if written application for such disclosure is made by the patient and endorsed by the attorney.

§ 1401.26 Evaluation in connection with rehabilitation.

(a) Whenever a patient or former patient has been employed or is seeking employment and such employment is conditioned upon his status or progress in a treatment program, an evaluation of such status or progress by qualified medical personnel may be furnished to responsible employment services, agencies, or employers which have demon-

strated their willingness to employ, or assist in the employment of, present or former drug abusers in a drug abuse treatment or rehabilitation program. Such organizations, agencies or employers shall maintain such evaluation as confidential and shall not disclose any part therof to any other person or organization. Any disclosure under this section shall be subject to all of the following conditions:

(1) The request for such an evaluation must be in writing and signed by the patient.

(2) The request must identify the employer (or official therein) cooperating in the patient's rehabilitation program.

(3) The treatment organization must verify the authenticity of the request by telephone or other means of communication and ascertain the extent that the information is need to verify the patient's treatment status.

(4) The information shall be limited to that reasonably necessary in view of the type of employment involved.

(5) No information may be furnished by a treatment organization unless the organization is satisfied on the basis of past experience or other credible information (which may in appropriate cases consist of a written statement by the employer) that such information will be used for the purpose of assisting in the rehabilitation of the patient and not for the purpose of identifying the individual as a patient in order to deny him employment or advancement because of his history of drug abuse.

(b) Information in the nature of a general evaluation of a patient's present or past status in a treatment program may be furnished to members of the patient's family if, in the judgment of a qualified physician or counsellor, such information would be helpful in treatment of rehabilitation of the patient and the patient makes a written request for such information to be furnished.

§ 1401.27 Disclosure for purposes of collecting health or other insurance claims.

A patient who has entered a drug abuse prevention program for diagnosis or treatment may for the purpose of such diagnosis or treatment (including the financing thereof) authorize the disclosure of information contained in his record to the extent necessary to support a claim for payment or reimbursement under a health or other insurance program carried by or in behalf of the patient and under which such patient is a beneficiary or participant. Any such disclosure shall be limited only to information which is directly relevant to, and necessary in support of, a claim for payment or reimbursement under such health or insurance program for the benefit of the patient and any information so disclosed remains subject to all of the restrictions of this part with respect to any further disclosure.

Disclosures Without Court Authorization and Without Consent of Patient

§ 1401.41 Disclosure without consent in general.

(a) Disclosure of a patient's records may be made without the consent of the patient and without authority of a court order as follows:

(1) To medical personnel to meet a medical emergency; and

(2) To qualified personnel for purposes of research, audits, or program evaluation.

§ 1401.42 Medical emergency.

Disclosure to medical personnel, either private or governmental, is authorized without the consent of a patient only when necessary to meet a bona fide medical emergency and only to the extent necessary to meet such emergency. For the purposes of this section a bona fide emergency may be considered to exist whenever competent medical authority has determined that the life or health of the patient involved may be impaired and medical treatment without the record could be detrimental to the patient's health. Where, for example, a person is incarcerated and claims to be a patient in a methadone treatment program, this claim may be verified by inquiry to the treatment center administering the program or to a registry such as is referred to in § 1401.43 in order to avoid overdose on the one hand, or the danger of untreated withdrawal on the other.

§ 1401.43 Records maintained in connection with chemotherapeutic treatment.

The communication of information relating to patient identity and dosage between or among programs approved by the Commissioner of Food and Drugs pursuant to § 130.44 of this title, or between such programs and a registry serving them, shall not be considered as a disclosure in violation of section 408(a) of the Act (21 U.S.C. 1175(a)), but any such information received by any such registry shall be fully subject to section 408 of the Act and to the provisions of this part.

§ 1401.44 Research, udits, and program evaluation.

(a) Disclosure without consent is authorized to qualified personnel for the purpose of conducting scientific research, management audits, financial audits, or program evaluation, but such personnel may not identify, directly or indirectly, any individual patient in any report of such research, audit, or evaluation, or otherwise disclose patient identities in any manner. Information so obtained may be used in enforcing lawful requirements imposed with respect to the operation of treatment programs employing controlled substances, but section 408(c) of the Act (21 U.S.C. 1175(c)) specifically prohibits the use of patient records to initiate or substantiate any criminal charges against a patient or to conduct any investigation of a patient, except as authorized under a court order granted under section 408(b)(2)(C) (21 U.S.C. 1175(b)(2)(C)). As used in this section, the term "qualified personnel" means persons whose training and experience are appropriate to the nature of the work in which they are engaged, and who are performing such work with adequate administrative safeguards against unauthorized disclosures.

Criminal Penalties

§ 1401.51 Penalty for unauthorized disclosure.

Subsection (e) of section 408 of the Act (21 U.S.C. 1175) provides that except as authorized under subsection (b) of that section, any person who discloses the contents of any record referred to in subsection (a) of that section shall be fined not more than $500 in the case of a first offense, and not more than $5,000 in the case of each subsequent offense.

Interpretation of Section 408(b)(2)(C) in Relation to Other Laws

§ 1401.61 Relationship of section 408(b)(2)(C) to other provisions of section 408 and to other legislation generally.

Section 408(b)(2)(C) of the Act (21 U.S.C. 1175(b)(2)(C)) empowers the courts, in appropriate circumstances, to authorize disclosures which would otherwise be prohibited by section 408(a). Both the positioning of this authority in the bill as initially passed by the Senate and the explicit crossreference in section 408(a) of the final Act make clear the congressional intent that section 408(b)(2)(C) operate as a mechanism for the relief of the 408(a) strictures and not as an affirmative grant of jurisdiction to authorize disclosures prohibited by other provisions of law, whether Federal or State. By the same token, it should be noted that the authority which section 408(b)(2)(C) of the Act (21 U.S.C. 1175(b)(2)(C)) confers on courts to issue orders authorizing the disclosure of records applies only to records referred to in section 408(a) (21 U.S.C. 1175(a))—that is, the records maintained by operating treatment or research programs, and not to secondary records generated by the disclosure of the 408(a) records to researchers, auditors, or evaluators pursuant to section 408(b)(2)(B).

§ 1401.62 Scope of orders; relationship to confidentiality provisions of Public Law 91-513.

(a) It is abundantly clear that section 408(b)(2)(C) was not intended to confer jurisdiction on any court to compel disclosure of any information, but solely to authorize such disclosure. An order or provision of an order based on some other authority, or a subpoena, or other appro-

priate legal process, is required to compel disclosure. To illustrate, if a person who maintains records subject to section 408 (a) of the Act is merely requested, or is even served with a subpoena, to disclose information contained therein which is a type whose disclosure is not authorized under section 408 of the Act or any of the foregoing provisions of this part, he must refuse such a request unless, and until, an order is issued under section 408(b)(2)(C). Such an order could authorize, but could not, of its own force, require disclosure. If there were no subpena or other compulsory process, the custodian of the records would have the discretion as to whether to disclose the information sought unless and until disclosure were ordered by means of appropriate legal process, the authority for which would have to be found in some source other than section 408 of the Act. This result is compelled by the language of section 408(b)(2) itself. The words used, "the content of such record may be disclosed * * * if authorized by an appropriate order" are too explicit and too well established as words of art to be interpreted as meaning "the content of such record shall be disclosed if required by an appropriate order."

(b)(1) This interpretation of the permissible scope of a 408(b)(2)(C) order is not only appropriate in the light of the purposes, language, and legislative history of the Act in which it appears, but also is necessary in order to harmonize that section with other legislation dealing with a narrower aspect of the same subject matter. By sections 3(a) and 502 (c) of the Comprehensive Drug Abuse Control and Treatment Act of 1970 (42 U.S.C. 242a(a); 21 U.S.C. 872(c)), Congress conferred on the Secretary of Health, Education, and Welfare and on the Attorney General, respectively, power to authorize persons engaged in drug research to withhold names and other identifying characteristics of persons who are the subject of such research, and expressly provided that when such authority has been obtained, its holder may not be compelled to disclose identifying information "in any Federal, State, or local civil, criminal, administrative, legislative, or other proceedings * * *"

(2) If section 408 of the 1972 Act were to be interpreted as an independent grant of authority to compel testimony, it would obviously be in direct conflict with the provisions of the 1970 Act discussed above. This becomes significant, for example, in the case of methadone, which for the purpose of treating opiate addiction on a longer-range basis is classified as an experimental drug which may not be administered except in connection with research. Nothing in either the language or the legislative history of the Act indicates any intent on the part of Congress to amend the provisions of the 1970 Act or to reduce the protection which can be afforded under them. Since the language of section 408 permits, if it does not require, a construction which harmonizes with the 1970 Act, it clearly should not be construed to authorize a court order in derogation of any exercise of the authority of the Secretary of Health, Education, and Welfare under section 242a(a) of title 42, United States Code, or the Attorney General under section 872(c) of title 21, United States Code.

INTERPRETATIVE GUIDELINES FOR APPLICATIONS AND ORDERS UNDER SECTION 408(b)(2)(C)

§ 1401.71 Applications for orders should be restricted to records of specified patients.

Section 408(b)(2)(C) empowers courts of competent jurisdiction to authorize disclosure only on a showing of good cause. That section expressly provides that in assessing whether good cause exists, the court must weight the public interest and the need for disclosure against the injury (a) to the patient, (b) to the physician-patient relationship, and (c) to the treatment services. Because these factors can only be weighted with respect to the particular patient involved, any application for such an order should relate only to the records (or a part thereof) of a specific patient and should include an identification of the patient and an indication whether the application is being made with or without his consent. This conclusion is buttressed by the form of section 408, which appears to have been deliberately cast in terms of the individual patient, e.g. section 408(b)(1), "If the patient * * * gives his written consent * * *." and 408(b)(2), "If the patient * * * does not give his written consent * * *", suggesting an intention that the disclosure order be limited to the records of a particular patient who either did or did not consent to the disclosure.

§ 1401.72 Information which should be furnished in support of application.

In those cases in which an application is not made by or with the consent of the patient, or is not joined in or consented to by the person or organization responsible for the records to which it relates, the Act implicitly requires that such application be supported by adequate information to enable the court to make the following findings:

(a) The nature of the public interest that would be served by granting the application;

(b) Any actual or potential injury, either economic or social, that could result to the patient or to the relationship of the patient to his physician;

(c) The effect that an order of disclosure would have on the administration of the drug-abuse prevention program; and

(d) A clear showing that the interests of the public are substantial in relation to possible injury to the patient or to the patient-physician relationship.

§ 1401.73 Suggested safeguards against unnecessary disclosures.

Section 408(b)(2)(C) implicitly negatives any court order requiring unlimited disclosure when limited disclosure would serve the purpose. It states that "in determining the extent to which any disclosure of all or any part of any record is necessary," the court is required to impose appropriate safeguards against unauthorized disclosure. To facilitate compliance with this requirement, it would be within the intent and spirit of this provision of section 408 that any such court order:

(a) Limit disclosure to those parts of the patient's record deemed essential to fulfill the objective for which the order was granted;

(b) Limit disclosure to those persons whose need for the information is the basis for the order;

(c) Require, where appropriate, that all information disclosed be held in camera; and

(d) Include any other appropriate measures to keep disclosure to a minimum, consistent with the protection of the patient, the physician-patient relationship and the administration of the drug abuse prevention program.

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